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SCIENTIFIC ARTICLES

Morphology and a Cure for Cancer, *Thelma Brumfield Dunn, M.D.* 101
What Makes Us Grow As We Do, *Minnie B. Goldberg, M.D.* 110
The Psyche and the Skin: Their Interrelationships, *Ruth Ellen Christensen, M.D.* 117

SPECIAL ARTICLE

The Child with Cerebral Palsy and His Family, *Edith Meyer Taylor, Ph.D.* 123

REGULAR FEATURES

World Health Organization 127
Past Presidents of AMWA, ESTHER POHL LOVEJOY, M.D. 132
These Were The First, *Elizabeth Bass, M.D.* 133
Album of Women in Medicine, MARY ELIZABETH BATES, M.D., *Esther Pohl Lovejoy, M.D.* 134
Opportunities for Women in Medicine 135
News of Women in Medicine 136
Book Notices 143

AMERICAN MEDICAL WOMEN'S ASSOCIATION

Nominations 128
Proposed Changes: Constitution and By-Laws 128
President's Message, *Camille Mermod, M.D.* 129
Annual Meeting 129
Reports from Committees, On Reinsurance, *Ruth Ellis Lesh, M.D.* 130
News from the Branches 131
Mid-Year Board Meeting, 1954 137

MISCELLANEOUS

Editorial Board ..... Adv. p. 6
Officers of the A.M.W.A. ..... Adv. p. 8
Standing Committees ..... Adv. p. 12
Branch Officers ..... Adv. p. 18
Junior Branch Officers ..... Adv. p. 24
International Correspondents ..... Adv. p. 26
Editorial Forecast ..... Adv. p. 34
General Information ..... Adv. p. 44
Index to Advertisers ..... Adv. p. 46
Index to Products Advertised ..... Adv. p. 46

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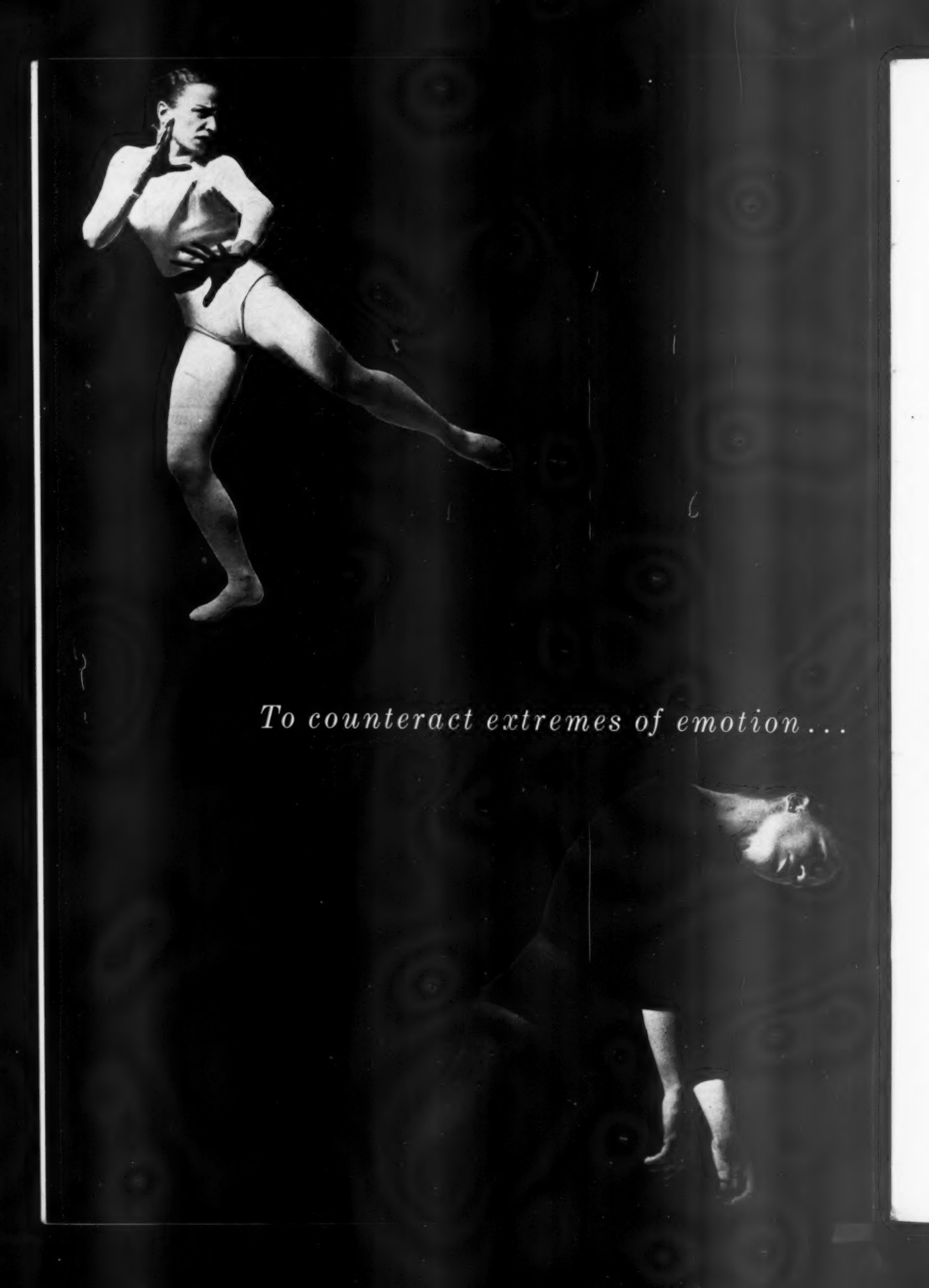
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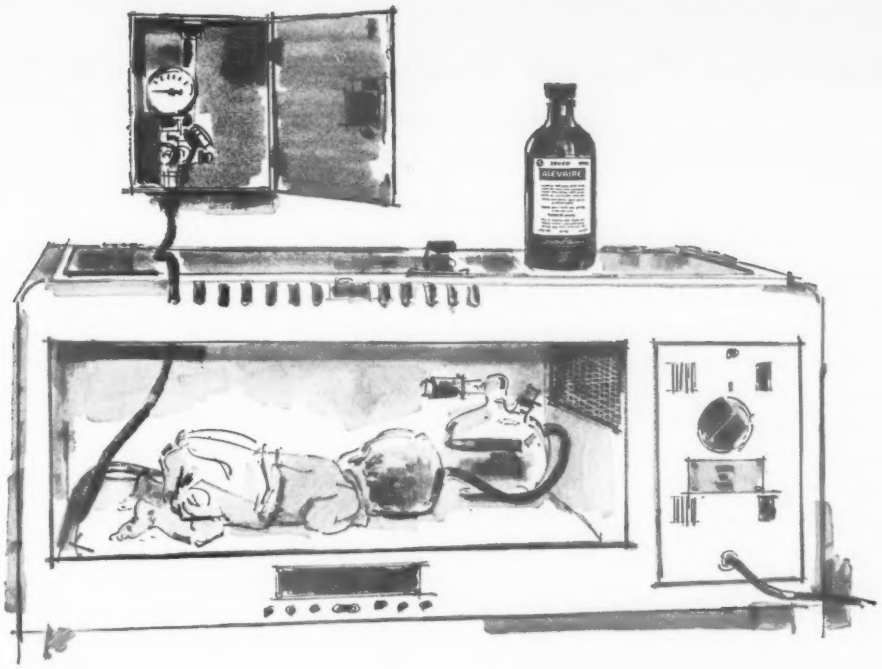

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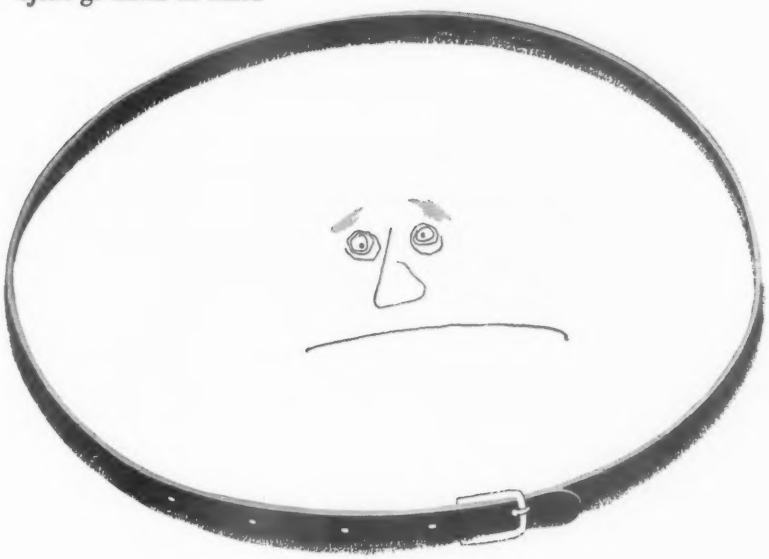
depression *and* obesity

often go hand in hand



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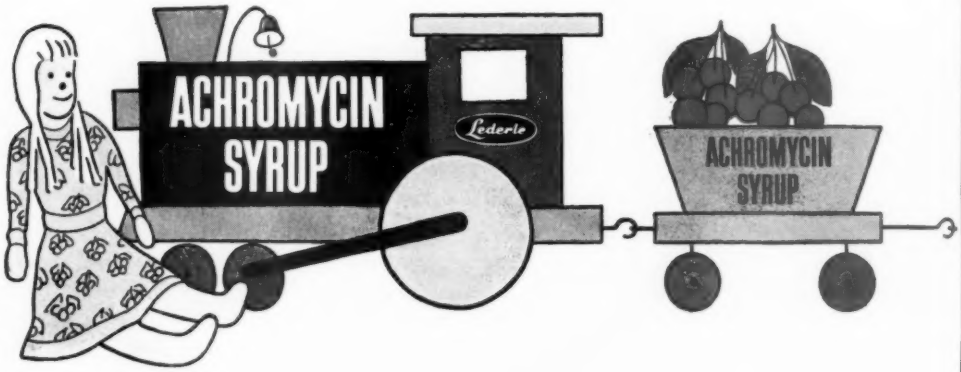

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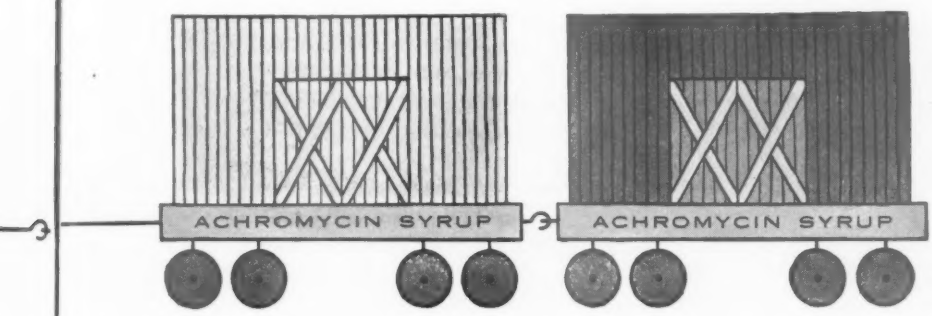

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(Continued on page 16)

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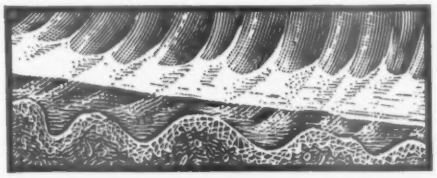

VAGISEC liquid penetrates to trichomonads buried among the vaginal rugae and imbedded in mucus and desquamated cells.

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Office treatment. Expose vagina with speculum. Wipe walls dry with cotton sponges and wash thoroughly for about three minutes with a 1:250 dilution of VAGISEC liquid. Remove excess fluid with cotton sponges. Office treatments are an integral part of the Davis technic.

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1. Davis, C.H.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954.
2. Davis, C.H.: West. Jour. Surg. 63:53 (Feb.) 1955.
3. Davis, C.H.: J.A.M.A. 157:126 (Jan. 8) 1955.

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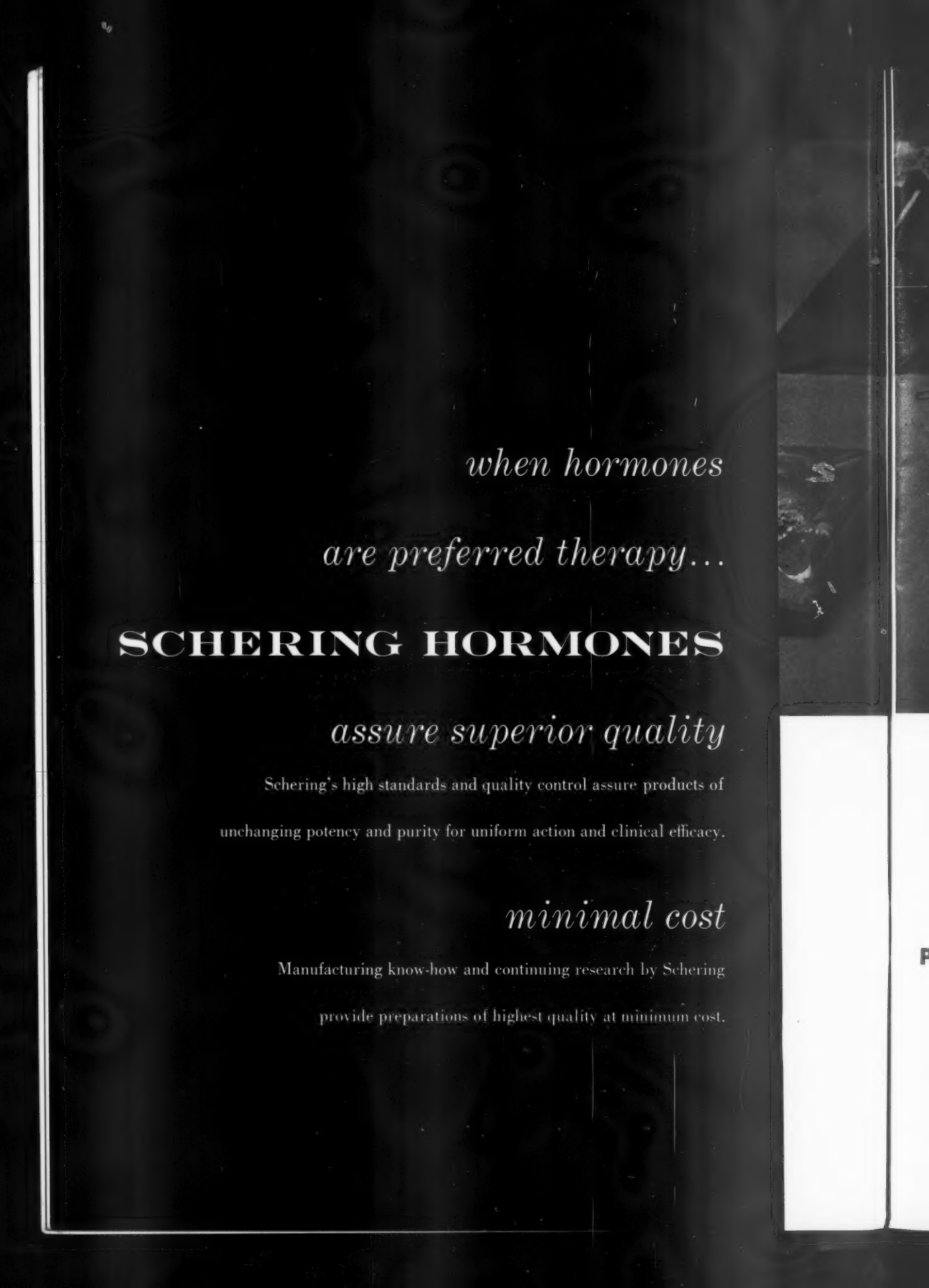
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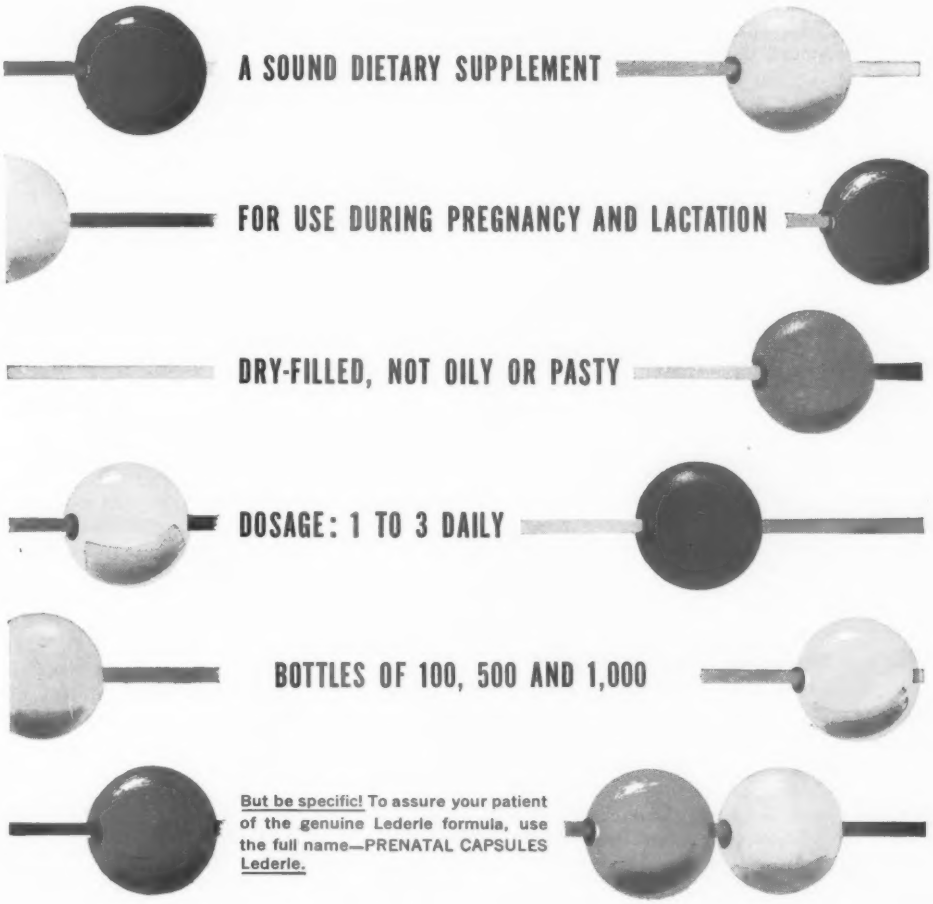

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(Continued on page 22)

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1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared with Collaboration of the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Baltimore, Waverly Press, 1952.

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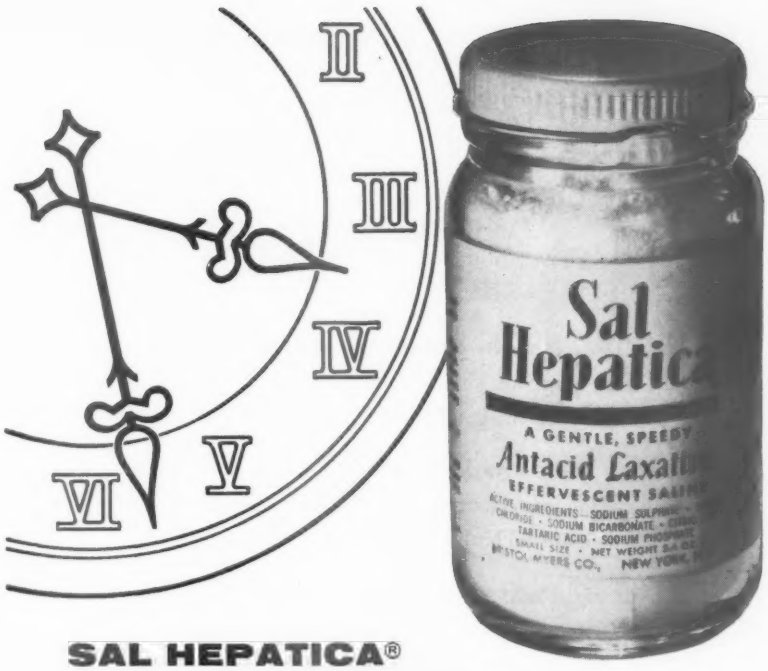

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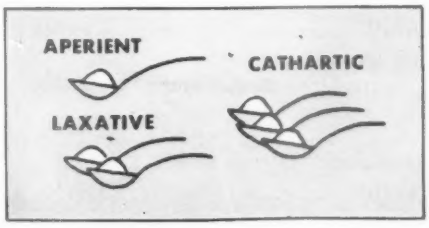

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References:

1. The Physiological Basis of Medical Practice. 1945. p. 486.
2. New England J. Med. 235:80, July 18, 1946.

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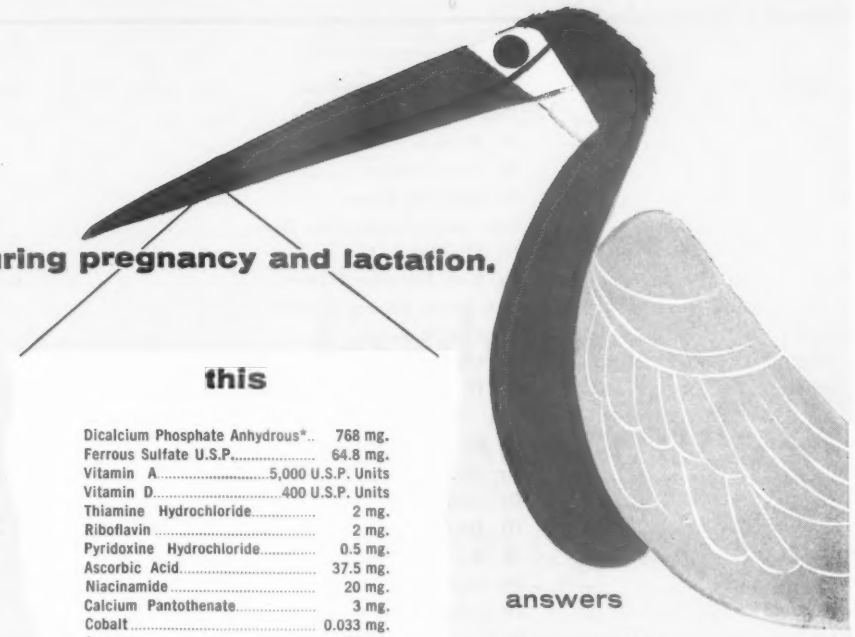

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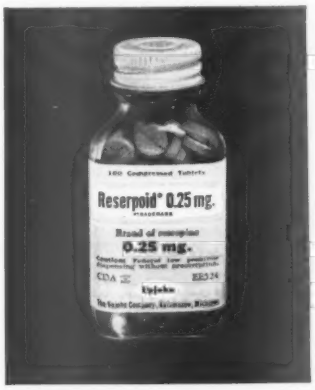

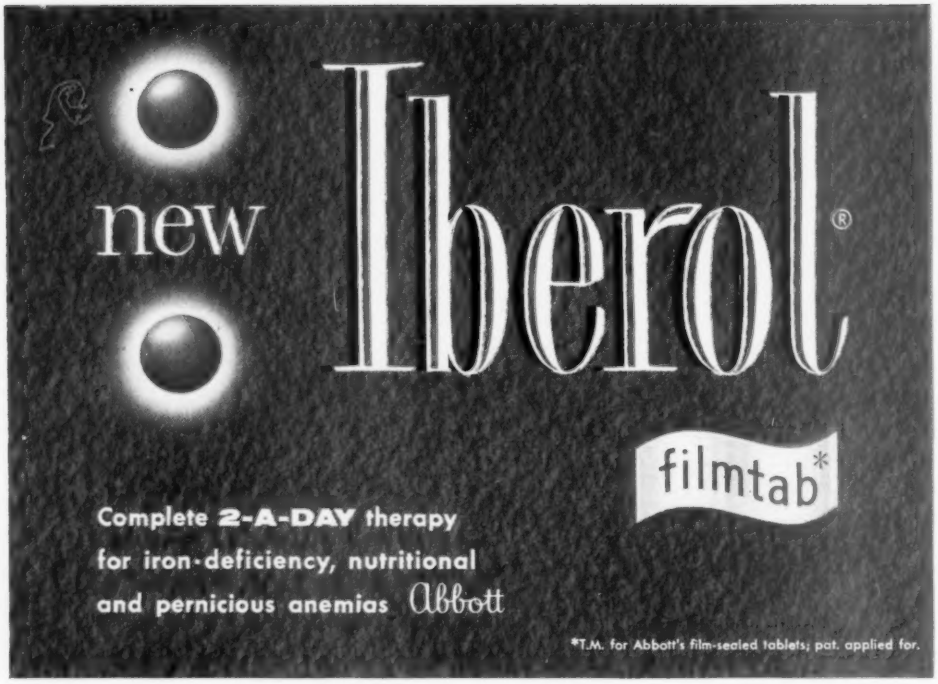

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From The Four Corners

NO HYPEREMESIS AND LITTLE ECLAMPSIA AMONG AFRICAN WOMEN

Toxaemia of pregnancy is rare in primitive races. If hyperemesis gravidarum is of toxaemic origin, this rarity is significant. It may be that neurosis initiates the vomiting which presently increases to cause toxic changes. Whatever the cause and the cycle, the African woman seems immune.

Eclampsia, also, is rare. Five cases have occured in five years among 655 hospital deliveries. Search for an explanation of the rarity of this phenomenon reveals the fact that blood pressure readings in African pregnancy are appreciably lower than in the European and hypertension appears to be much less common in the Bantu than in the white races. There may be some relationship between these factors but analysis has not been sufficiently exhaustive to go further than to note that it seems as if there is some definite relationship between the basic level of blood pressure and eclampsia. (From "Some Aspects of Obstetrics in the African" by James Montgomery, M.D., F.R.C.S., in the *Central African Journal of Medicine*. Jan. '55.)

FAMILIES OF WOMEN PHYSICIANS IN FINLAND

Statistics show that, of the 2,170 physicians in Finland on December 31, 1951, 461 were women; 60 percent of the women physicians were married, the average age at marriage being 27 years. The husbands of 49 percent of the married medical women were doctors. The number of children averaged 2.17 for all married physicians. (From "Foreign Letters," *J.A.M.A.*, 157: 610, Feb. 12, '55.)

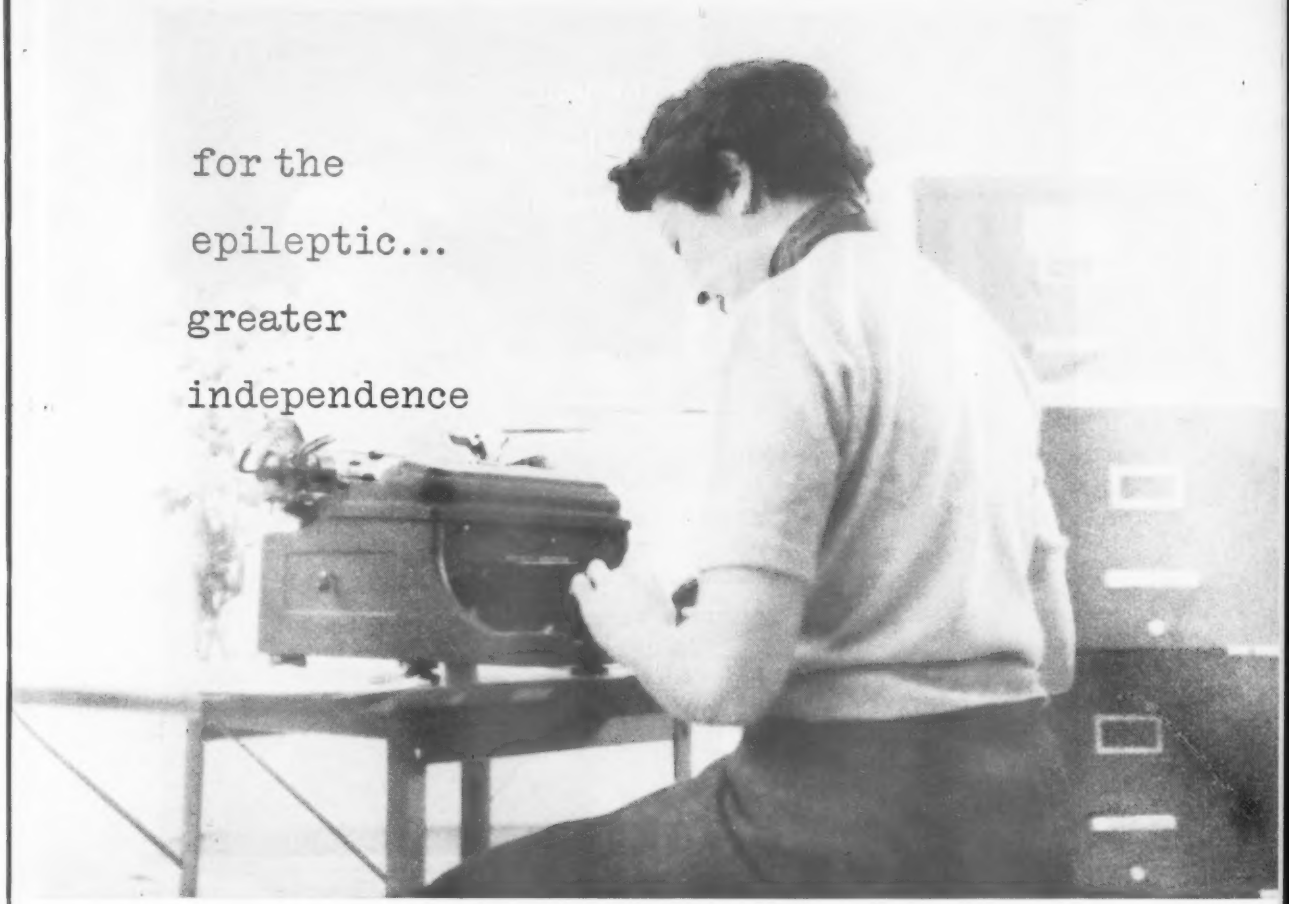
MAN'S LIFE SPAN—HOW SHORT!

The length of human life varies a great deal according to country. It is much shorter, for instance, in Asia and in Africa than in Europe or North America.

Although the life expectancy of some animals, such as the crocodile and the whale, who live to a very old age—is not exactly known, scientists believe that these two animals hold the record of longevity together with the giant turtle. The following table reproduced from a work by Korschelt, tells of a dozen or more animals that surpass man as to length of years.

	Average Age (years)
Giant turtle	at least 200
Crocodile	several centuries
Whale	several centuries
Elephant (wild)	150 to 200
Elephant (in captivity)	80 to 120
Pearl oyster	at least 100
Pike, Salmon, Carp	80 to 100
Falcon, Owl, Raven, Magpie, Parrot	60 to 100
Sole	80
Eagle, Wild Goose	80
Stork	70

It is a well-known fact that the duration of animal life is much shorter than that of plant life. Some bushes are known to be more than 13,000 years old. (UNESCO)



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Morphology and a Cure for Cancer

Thelma Brumfield Dunn, M.D.

A LITTLE OVER FIFTY YEARS AGO, the first mammary tumor in a mouse was successfully transplanted, and an active period of experimental cancer research began.[1,2] Rapid progress in the understanding and, later, in the control of bacterial diseases had been made possible by the discoveries of Pasteur and Koch. Experience with bacterial infections proved the value of a susceptible experimental animal in the investigation of human disease. Consequently, the discovery that cancer existed in a lower animal and could be transmitted to other members of the same species gave rise to the hope that success might be attained in controlling neoplasms.

Unhappily, this hope has not been realized, and a satisfactory treatment of cancer is yet to be achieved. It is true that much knowledge has been acquired during this half century, but instead of simplifying the problem it has added to our perplexity. An overwhelming volume of facts has been accumulated, but these facts cannot be fitted into any coherent, unified concept which would give a clear direction for future work. Almost no general rules can be stated regarding cancer, because exceptions must so often be cited. It is difficult even to frame a definition which embraces all the facts. That concise old favorite, "an autonomous new growth of tissue"[3] has been discarded because we have learned that many cancers, prostatic for example, are not autonomous, since they respond to the same mechanisms that regulate normal cells. Nicholson,[4] probably the most philosophical student of cancer, said that it was "impossible to define."

During the past 50 years, the morphology of cancer in laboratory animals has been studied intensively. The experimental animal has offered opportunities which cannot be found in human material. The tissue can be obtained absolutely fresh, without any delay in the operating room or in waiting for an autopsy permit. Cytologists are enabled to study delicate structures which would be destroyed by even slight post-mortem change. The histogenesis of cancer can be followed in experimental animals, since the tumor can be removed and examined at its earliest inception and also in later stages of development in animals from the same experimental

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groups killed at selected intervals. Because of their small size, animal tumors, especially those of mice, can be sectioned whole and the entire tumor examined. Human tumors, unless they are very small, or unless one prepares large section mounts according to a difficult technique, must be examined piecemeal, using a few or many sections taken from disconnected areas. Animal tumors can be transplanted to other members of the same inbred strains, and the biologic behavior and morphology studied in numerous hosts through a long period of time. Other advantages of animal tumors in morphologic studies could be cited. These advantages have contributed many details to augment our knowledge of the morphology of cancer. We have indeed acquired an enormous fund of information in the last 50 years. It is time to ask of what importance this knowledge may be to the highest aim of cancer research, which is the control and cure of the disease in man. Some facts which are emerging, or have emerged in these years, will be considered.

The morphologist is the first to admit the limitations of his tools and his vision. The morphology of a tumor is of primary importance in human cancer because it reflects biologic behavior. This reflection, however, is not exact, no rule of thumb can be followed, and each group of tumors requires a different set of criteria for estimating its degree of malignancy. This is one reason so much time is required to train a pathologist in the diagnosis and prognosis of cancer; the histologic picture must be learned directly from observation, and cannot be learned from a formula or a book.

Morphology is not a dead science. New instruments and new procedures are being developed constantly. The electron microscope and the phase microscope are bringing hitherto unseen structures into view. New procedures in histochemistry are giving accurate information as to the localization of particular chemical substances within the cell. Tissue culture permits the simultaneous observation of biologic behavior and morphology. Though the morphologist sees "through a glass darkly," he has every expectation that advances in the next few years will provide him with more light and greater precision. The present shortcomings in morphology, which should never be overlooked, will some day be greatly reduced.

Qualitative Morphologic Features of Malignant Cells

First, it has been impossible to detect any qualitative morphologic feature universally present in a malignant cell but absent in all normal cells. Such a feature has been searched for diligently. If such a difference could be found, some treatment which would take advantage of this feature and selectively injure the undesirable tissue might be anticipated. There are quantitative differences in plenty, but these are not universally present in all cancer cells and absent from all normal cells. Our old medical student picture of a malignant cell as one of large size with an increased fluid content, hyperchromatism, loss of differentiating characters which developed with function (such as keratin formation in epidermal cells, colloid from thyroid cells, and mucus from glandular cells), multipolar mitoses, loss of polarity, and other supposed criteria of malignancy, is reliable only when the comparison is made between selected cells from highly anaplastic tumors and normal cells of the same histologic origin. But even highly anaplastic tumors probably contain cells which do not have all these features. An illustration is furnished by a selection of isolated cell nuclei taken from fibrosarcomas developed by Earle[5] from fibroblasts grown in tissue culture. Cell nuclei have been taken from different transplanted lines of fibrosarcomas and have been photographed and mounted on a plate in close proximity with nuclei from regenerating fibroblasts, derived from a 7 day old healing wound in a mouse (Fig. 1). Most of the malignant cell nuclei are seen to be larger, more rounded, and with less resemblance to mature fibroblast nuclei than those from the regenerating non-neoplastic tissue; but the nuclei from other cells in the neoplasms are not distinguishable from those of hyperplastic normal cells. Generally the tumor cell is larger than the normal, but hepatomas in the mouse often contain masses of cells which are smaller (Fig. 2). In the same way, exceptions can be cited for every proposed morphologic criterion of malignancy. If all cancer cells were larger than the corresponding normal cells, a search might be made for an agent which would destroy the largest cells in a tissue or organ and allow the smaller cells to survive. If any consistent morphologic difference is ever found, it will offer a direct point for attack.

The Papanicolaou technique[6] for cytologic smears makes possible the examination of individual cells. In smears from cancerous tissue, a sufficient number of cells reveal the morphologic criteria of malignancy to permit a high percentage of correct diagnoses. The examination of the blood smear in human leukemia is similarly a cytologic examination of individual cells, and the differences, such as increased size and lack of differentiation, are sufficiently clear for highly accurate diagnosis from

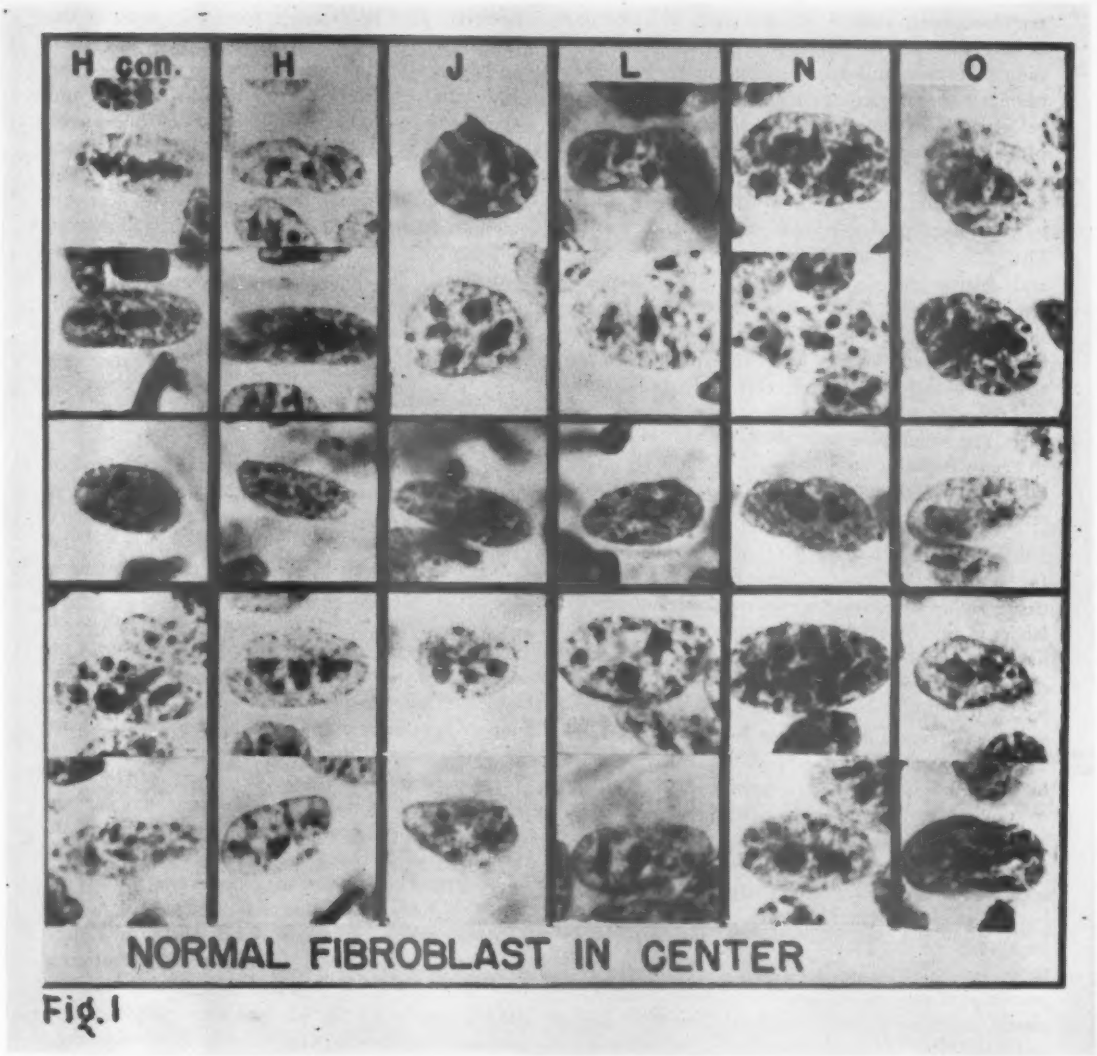

Fig. 1. Isolated nuclei taken from transplanted fibrosarcomas in mouse, compared with nuclei from normal fibroblasts in a healing wound. The fibrosarcomas, except for H control, resulted when tissue cultures of fibroblasts were exposed to methylcholanthrene, and later transplanted subcutaneously into mice of the same strain as that from which the fibroblast cultures were derived. The H control strain also became neoplastic, though it had no known exposure to the carcinogen. The non-neoplastic fibroblast nuclei are arranged in the center row. Some of these are as large and appear as "anaplastic" as nuclei taken from the neoplastic tissue. No consistent morphologic difference could be found between all nuclei from neoplastic and non-neoplastic tissue. Orcein-acetic squash preparation (X 1000).

the blood smear alone. Cytologic study of leukemia in mice, however, has shown that the malignant cell cannot be distinguished morphologically from the normal embryonic cell during some phase of its development.[7] In leukemia, more than in most neoplasms, a remarkably uniform population of similar cells is found. This may be one reason why leukemia has thus far been more successfully controlled by chemotherapy than any other neoplastic disease. Drugs are available which can selectively injure and destroy cells, when they are greatly altered from the normal, in a uniform fashion and to a similar degree. However, it is probable that, even in highly anaplastic cancers, many cells remain which, though biologically altered and truly cancerous, still resemble normal cells in their morphologic features, and behave like normal cells in their response to drugs. A cancer cure, to be really effective, must kill all the malignant cells, for if any remain, recurrence is to be expected.

Morphologists have not been alone in their search for a specific difference in cancerous and normal tissue. The chemists have performed herculean labors in this quest. A vast amount of useful data has been accumulated, but, like the alchemist's search for the philospher's stone, the particular objective has not been attained, and a precise and invariable difference has not been found. This is well summarized by Winzler[8] who stated that: "Survey of this problem has failed to reveal a clear demonstration of any chemical characteristic which may account for the difference in growth behavior of normal and tumor tissue. This does not mean that such characteristics are non-existent. It does mean, however, that more and more refined methods must be applied to the problem if such differences are to be found." He also pointed out that, "Recent studies lend support to the generalization that neoplastic tissues are rather closely related metabolically and chemically." It should be remembered, however, that the neoplastic tissue which the chemist analyzes must come in considerable bulk, without much admixture of normal cells. This means that only rapidly growing, and usually greatly altered, neoplastic tissue can be used for chemical analysis. Morphologists are testing many new developments in histochemistry, hoping to localize the chemical differences to particular cells and even to particular areas within the cell. They observe that the histochemical and enzyme content of cancer tissue usually varies from the normal, but not in a consistent fashion. For instance, glycogen in the normal liver of a mouse follows the lobular pattern of distribution.[9] It is scanty or abundant, depending upon the physiologic state of the animal. Glycogen in a hepatoma, however, may be excessive when compared to the normal, or it may be deficient, and may vary from one extreme to the other in different areas of the same tumor. It shows no regular distribution, and appears to be unaffected by the physiologic state of the host (Fig. 3). Thus, although the glycogen content of the neoplastic tissue differs from that of normal hepatic tissue, there is not a consistent difference. Assuming that one could find a substance which would selectively injure either the glycogen-laden or deficient cell, it would still not select cancer cells for destruction. The same situation probably exists for other products in both normal and neoplastic cells.

Organoid Reproduction with Variation of Cell Types

A second condition, revealed clearly by morphologic studies of certain groups of animal tumors, is a serious obstacle to the hope of a universal cure for all neoplasms. When the entire tumor and the adjacent tissue can be observed, we do not see a change in a single cell type, with a mass of obviously malignant tissue clearly demarcated from a mass of normal cells of similar derivation. The concept of cancer as a sudden, abrupt change in a single isolated cell must be abandoned. Many animal tumors appear to be organoid. The malignant change seems to reproduce all structures in an organ, and a variety of cell types results. Nicholson[10] and Willis[11] have emphasized this same feature in many human tumors. The mammary tumor of the mouse is an excellent illustration.[12] One seldom finds a mammary tumor of uniform structure throughout (Fig. 4). One area reproduces acini (Fig. 5), another shows duct-like epithelium, and in others a bewildering hodge-podge of glandular epithelial patterns may be found. Rarely, epidermal tissue with keratinization develops (Fig. 6), and even malignant appearing fibroblasts may be found in the stroma (Fig. 7). Also significant, in relation to hope for a cure, is the change to be found in the presently non-neoplastic adjacent tissue. This often shows "preneoplastic" areas in which the epithelial structures are

Fig. 2. Spontaneous hepatoma in mouse, showing neoplastic tissue on left, and a small isolated nodule in lower right. Tumor is compressing normal hepatic cells which are flattened at one margin. Hepatoma cells are smaller than the hepatic cells. Hematoxylin and eosin (X 100). Fig. 3. Spontaneous hepatoma in mouse, showing non-neoplastic hepatic tissue on right in which glycogen is evenly distributed according to lobular pattern. In hepatoma on left some cells are heavily packed with glycogen, others contain none, and there is no uniform distribution. Periodic-acid-Schliff technique (X 65).

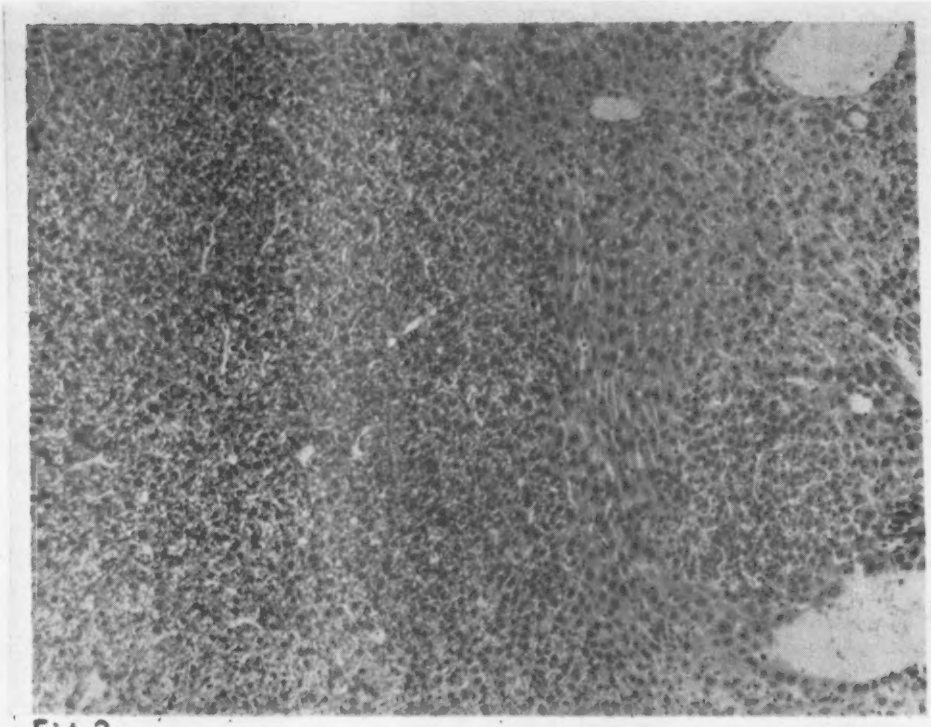

Fig. 2

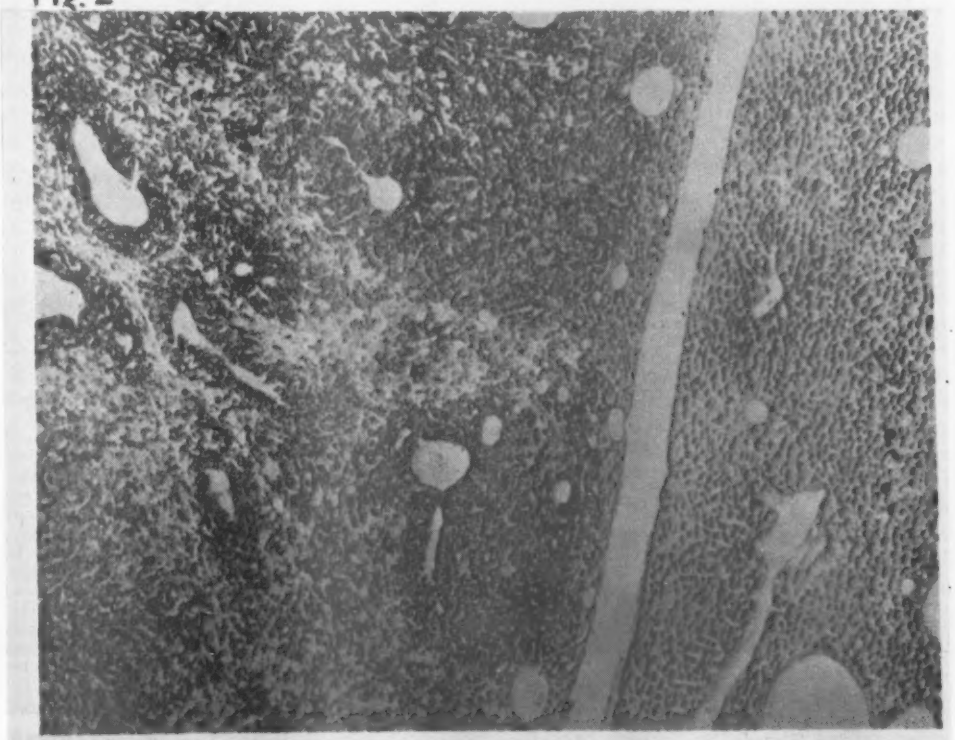

Fig. 3

hyperplastic and otherwise altered. As Willis[11] said of certain human tumors, the cancer appears in an "extensive field of predisposed epithelium." Mammary tumors in the mouse are usually multiple. The malignant tendency is not reserved for a few curiously predestined cells, either already residing in or springing up in an otherwise normal tissue, but affects a whole tissue or organ system. The cancerous change appears most often as a gradation through ill-defined stages. At first glance, this is disheartening when one is looking for a cure. It is hard to conceive of an agent which would ferret out cancer cells showing a variety of morphologic features, some in the earliest stages of change, others far advanced, and destroy them without injury to normal cells of similar structure, scattered throughout the body. Recently, however, it has been demonstrated that some of these organoid mammary tumors in the mouse are dependent or conditioned; that is, they require a particular condition in the host before they can maintain themselves and grow progressively. Foulds[13] has described mammary tumors which first appeared in the mouse during pregnancy and receded after delivery. Some of these could be transplanted successfully to female mice only, indicating that a particular hormonal state was necessary in the host. A similar dependency has been demonstrated for thiouracil-induced thyroid tumors in the mouse, which can be transplanted successfully only into animals treated with thiouracil.[14] This inactivates the thyroid hormone, and creates an abnormal hormonal balance. Pituitary tumors have been induced in mice by complete destruction of the thyroid.[15] Excessive and continued stimulation of pituitary cells no longer kept in balance by circulating thyroid hormone is considered to be the mechanism of induction. Initially these cells are not permanently altered, for they will not grow if transferred to a normal mouse. They need continual stimulation, which is supplied if they are transplanted into a mouse with the thyroid tissue removed. In this environment, the cells grow progressively. Unfortunately for the hope of continued control of these dependent tumors, most of them eventually become independent, and grow in untreated animals. Morphologically, they may appear more anaplastic. This process has been termed progression.[13] It is a characteristic which has been demonstrated repeatedly in experimental tumors, and it is probable that many human tumors show a similar development. Some cases of prostatic cancer grow less rapidly if the amount of testosterone in the patient is reduced by orchidectomy or suppressed by estrogen. In this stage, the cancer is dependent to some degree. However, permanent cure by hormone alteration in the host has not been accomplished, perhaps because a process of progression, similar to that observed in animals, also operates in man.

Increased Mitotic Rate of Cells

A third morphologic feature of cancer tissue which has invited many investigations is its increased mitotic rate. Although an increased growth rate is only one of the many alterations to be found in cancer cells, it is the characteristic which most seriously threatens the welfare of the host. A high mitotic rate is usual in rapidly growing tissue, whether normal or cancerous. So far as can be determined, the various steps in the process of mitosis do not differ in cancer tissue, although bizarre forms are more common in some neoplasms. The relative number of mitotic figures may be as high in rapidly growing fetal tissue, or in some adult tissues. The bone marrow, lymphatic follicles, and the mucosa of the small intestine which constantly supply new cells are normal tissues in which the mitotic rate is higher than in many neoplasms. However, the normal adult organism can survive a depression in mitotic activity sufficient to injure seriously and even destroy cancer tissue. There are available a number of substances, the so-called mitotic poisons, which at the proper dose level will injure dividing cells but cause no permanent harm to resting cells. After this property was first recognized with colchicine,[16] much experimentation was undertaken to test its effect, and that of related chemical substances, on cancer. Therapeutic trials with these substances have usually disclosed toxic effects which make their use hazardous. It is possible, however, to synthesize new substances related to these compounds.[17] It is hoped that some may be found which will have a severe destructive effect on cancer tissue, but spare the normal tissue of the host. Even if such

Fig. 4. Tumor showing organoid structure. Center of tumor (upper left) reproduces ducts lined with squamous epithelium. Radiating tubules are lined with squamous or cuboidal epithelium, and tissue reproducing acini appears at the periphery. Hematoxylin and eosin (X 36). Fig. 5. Tumor reproducing mammary acini. In other areas of this tumor there were tubules lined with cuboidal epithelium, and solid nests of cells. Hematoxylin and eosin (X 100). Fig. 6. Tumor reproducing mammary acini on left. Area composed of small cysts lined with stratified squamous epithelium is seen on right. Hematoxylin and eosin (X 250). Fig. 7. Mammary tumor having both epithelial and mesenchymal elements. Fusiform cells in center appear to be neoplastic and resemble malignant fibroblasts. Hematoxylin and eosin (X 250).

Fig. 4

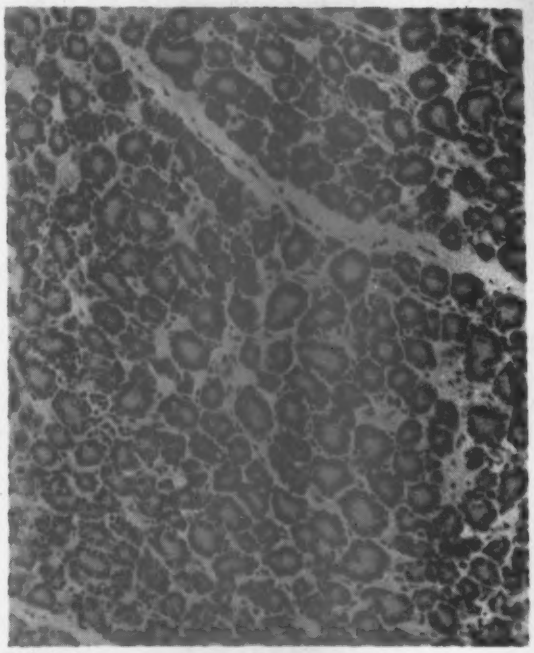

Fig. 5

Fig. 6

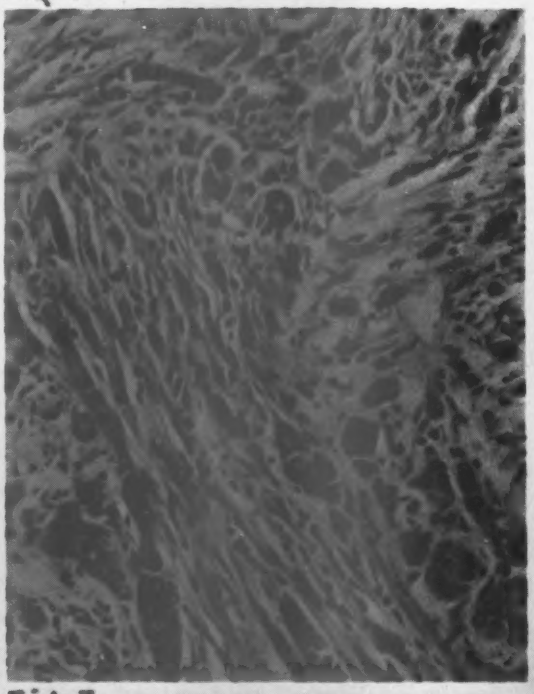

Fig. 7

substances fail to be curative when used alone, they might be useful adjuvants in the control of the more malignant neoplasms.

Transplantation of Tumors

Certain features in the biologic behavior and morphology of cancer have been learned from observations on transplantable tumors. These tumors give the experimentalist opportunities for study which cannot be furnished in human cancers, since these are limited to the life of the primary host. Some features revealed by transplanted tumors may be important in our search for a cure. Many lines of transplanted tumors, that is, tumors carried through successive hosts, appear to "accelerate" or show an "increased virulence" during the process of transplantation. Growth becomes more rapid, metastases more frequent, a higher percentage of successful transplantations is accomplished, and the cancer cell appears to be less restricted to a particular type of host. This has been shown especially in transplanted leukemia in the mouse.[7] Morphologic study has generally failed to detect any difference during this process of acceleration, although some leukemia lines are reported to show a more uniform population of cells, and an increase in mitochondria was reported in one line.[18] We have examined hepatoma lines in the mouse, in which a rapidly accelerated growth rate developed during transplantation, and have failed to find a morphologic difference except for a doubtful increase in mitotic figures.[9] It is probable that the same process of "acceleration" develops in some human tumors where the growth rate is slow at first and the tumor remains confined to a small area, then grows rapidly and kills within a short time. In addition to this change in behavior without a demonstrable change in morphology, a number of transplanted animal tumors have shown an abrupt change both in behavior and morphology.[9] In most instances this consists in a switch from an epithelial type of growth to one indistinguishable from a fibrosarcoma. Such changes are more difficult to detect in human carcinomas, but if they should occur often they would complicate further the problems of chemotherapy.

Another feature of transplanted tumor lines which may be significant in relation to human cancer is the individuality in behavior which different lines display even though morphologically indistinguishable. This has been most thoroughly studied with leukemia in mice.[7] In some lines, the tumor remains localized for long periods at the site of transplantation; in others, the cells enter the peripheral blood rapidly, and the animal may die in less than a week. In their spread, cells of different transplantable leukemias may show a predilection for certain organs such as the ovaries or kidneys. In some neoplasms, this individuality extends even to response to chemotherapy. The cells in some lines of leukemia are severely damaged by certain agents to which cells in other lines are resistant. Some lines have even developed dependence upon a chemical substance and flourish best when it is given to the host.[19] Yet no morphologic differences can be detected. A similar individuality may exist in human cancer. This may account for the variable response to chemotherapy in neoplasms which appear morphologically identical in cell type. When our knowledge is extended to a point where these differences can be identified, we may find that human cancers which appear similar in all respects may still require different clinical management. Our understanding of the mechanisms by which most anticancer drugs produce an effect is still very limited. Some of these drugs were discovered accidentally and are used empirically.

Other Features

Other features, not directly residing in the cancer cell, may finally be helpful in controlling the disease. Compared with a normal organ, a cancer usually has a more abundant blood supply with vessels that lack muscle and elastic fibers in the wall.[20] Consequently, it may be possible to injure the circulation in some cancers without serious damage to normal tissue. However, some cells in the periphery of the tumor which are not supplied by the newformed channels nearly always escape damage after vascular injury, and this may account for recurrence of the growth. Cancer tissue has no nerve supply except for pre-existing fibers, and this difference from normal tissue may offer a point of attack.[21] From whatever cause, the chemical and physical conditions in cancer tissue are sufficiently different from the normal to encourage the local growth and destructive effect of some organisms, and attempts are now being made to exploit this difference.[22]

Conclusion

Facts regarding the morphology of cancer which have been reviewed in this article are discouraging to the hope of a universal cancer cure in the near future. Many oncologists have misgivings about the recurrent statements in the lay press that cancer will be "licked" within a predictable period of time. If all cancer cells were of similar structure, and greatly different morphologically from all normal cells, we could entertain such a hope. Perhaps the most important thing we have learned in 50 years of cancer research is the complexity of the problem.

This means that efforts at control and cure must be increased and not diminished because of present failure. It looks now as if each form of cancer, and perhaps each case of cancer, may require individual treatment, and this calls for a vast store of knowledge. Cure in many cases may be impossible, but control, perhaps by using many combinations of treatment, may be achieved. The victory may be won not by a single decisive battle, but by a series of successful minor engagements.

Moreover, we may finally achieve a more effective control by prevention than by cure. Any disease which can be induced can, to some degree, be prevented. We have extensive information on the induction (and prevention) of cancer in animals by means of chemical and physical agents, environment, diet, hormonal alterations, and other factors, but relatively little on extrinsic factors which increase or decrease the incidence of cancer in man. We seem unable to evaluate such factors, even if they are suggested, as witness the present controversy on smoking. Our knowledge regarding geography, environment, and industrial exposure in cancer in man is woefully deficient, when compared with what we know of experimental cancer in animals.

A vast amount of money has been spent in the last ten years for the control of cancer. Some doubt that the returns have justified the expense. Yet these years have not been years of stagnation. In the clinical management of the disease, hormonal treatment has been developed for some forms, and antimetabolites and several chemical compounds have been successful in retarding the course of leukemia. The effect of virus inoculations has been studied, and many other substances have been tried which cannot yet be judged. A mass of data has been accumulated in the laboratory, but it may be years before its value in controlling cancer in man will be known. Far from being discouraged and ready to give up or wait, we must recognize the enormity of the task, and be ready to redouble our efforts. We are only beginning to know how much more we need to know.

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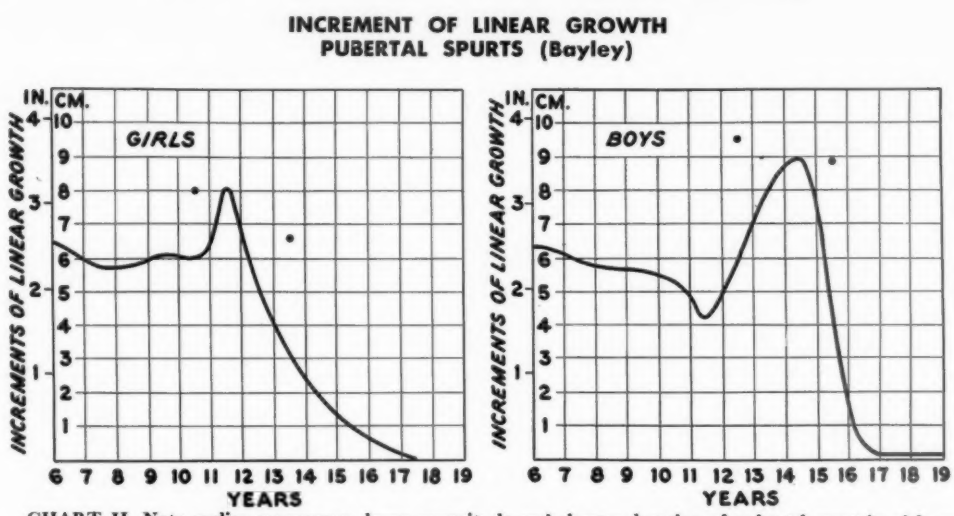

CHART II. Note earlier occurrence, lesser magnitude and shorter duration of pubertal spurt in girls as compared with boys.

carbohydrate metabolism, and regulating reaction to stress. Between the ages of eight and ten years, adrenal androgens, and perhaps estrogens, begin to appear in the urine.[6] Before long the gradual development of pubic hair may be noted; axillary hair appears somewhat later.

Between the ages of eight and eleven years, later in males than in females, pituitary gonadotropins begin to function, stimulating the male and female gonads to produce their respective androgens and estrogens. The androgens, from both the adrenal cortices and the testes, are anabolic and virilizing in action. It is this androgenic group of steroids which is responsible for the adolescent spurt of growth in boys. By contrast, adrenocortical 11-oxysteroid hormones, which control carbohydrate metabolism, are catabolic in nature. When present in excess, as in certain tumors or in hyperplasia of the adrenal cortex, they cause destruction of proteins and increased gluconeogenesis. In childhood, this leads to stunting of growth, obesity, and interference with sexual maturation.

In the normal boy, the size of the penis, especially its circumference, is an approximate index of androgen production. Normally, very little growth of this organ occurs between birth and eleven or twelve years, other than can be accounted for by general somatic increase in size. At about thirteen years, the genitalia begin to grow and develop rapidly, and from then on the male body commences to assume its masculine configuration, narrow hips, broad shoulders, increased muscularity, beard and body hair distribution, and lowered pitch of voice. Trunk length is particularly affected by androgens. Its increase balances the increased leg length developing since age ten, and once again at maturity the upper and lower body measurements return to approximately a one-to-one ratio.

Estrogens begin to make their appearance in the girl between the ages of eight and ten years. An approximate index of the concentration of circulating estrogens is the status of the breasts, uterus, labia

Fig. 1. Pituitary dwarfism. Man, age 39 years; height, 52½ inches; height age, 9½ years; bone age, 13 years. Tiny but perfectly proportioned midget with childish voice, progeric facies, lack of sexual development. Birth length normal; retardation in skeletal growth not apparent until age 6 years. *(Courtesy Dr. Gilbert S. Gordon.)* Fig. 2. Congenital hypothyroidism. Hypothyroidism recognized at one month of age and treated with desiccated thyroid until age 4, when treatment lapsed. A. After 2½ years without treatment: age 6 years, 4 months; height, 40 inches (normal for age 4); bone age, 3 years, 9 months; basal metabolic rate, minus 23 percent; blood cholesterol, 382 mg. percent. B. After 17 months of treatment with desiccated thyroid, ¾ grain daily: age, 7 years, 9 months; height, 45½ inches; bone age, 6 years; basal metabolic rate, plus 8 percent; blood cholesterol, 193 mg. percent. Note disappearance of myxedematous appearance. Height 11 months later 50½ inches, representing growth of 5 inches in less than one year. Fig. 3. Preadolescent hypogonadism (eunuchoidism). Man, age 45 years; height 72¼ inches; lower body measurement, 43 inches; upper body measurement, 29¼ inches; bone age, 18 years. Characteristic long arms and legs and short trunk; also tiny genitalia. Fig. 4. Precocious sexual maturity (neurogenic). Woman, age 20 years; height, 53½ inches; bone age, all epiphyses united. Mentally retarded. Menses began at 5 years of age.

Fig. 1

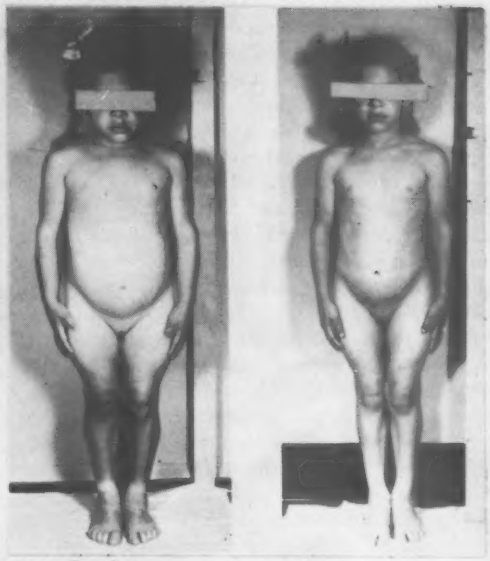

Fig. 2 A B

Fig. 3

Fig. 4

minora, and the degree of cornification of the vaginal mucosa. The labia majora, which are analogous to the scrotum in the male, are not dependent upon estrogens but upon androgens for their development. Estrogens do stimulate linear growth, but to a lesser degree than androgens; however, they accelerate epiphyseal closure more markedly than do androgens. Estrogens are responsible for the rounding of the feminine contours and the widening of the female pelvis. Although pubic hair usually appears before breast development begins, the reverse is frequently observed. The earliest sign of breast development is a gelatinous, puffy, cupola-like appearance of the areola, and this phenomenon usually antedates the onset of the menarche by two years. The lower and upper limits of normal for the menarche are considered to be nine and seventeen years; the average age at onset in this country is thirteen years. Interestingly enough, the parallelism of skeletal and sexual maturity is such that the first menstrual period is said to occur almost simultaneously with the closure of the distal interphalangeal epiphysis of the index finger.[7] The greatest increment of adolescent growth occurs in girls in the year preceding the first menstruation.

As shown in Chart II, the adolescent spurt of growth occurs earlier and is of lesser magnitude and shorter duration in girls than in boys, whereas the postadolescent deceleration of growth is more rapid in the girl than in the boy. These are the obvious reasons why women in general are shorter than men.

In the final analysis, it is the epiphyseal closing action of the gonadal steroids which keeps linear growth within bounds. In the absence of gonads, ossification proceeds slowly, but does proceed. Linear growth continues at a steady pace, but continues uninhibited over an abnormally long time, so that the preadolescent eunuchoid person ends up tall, with long arms and legs, short trunk, and correspondingly short sitting height (Fig. 3).

The premature and excessive activity of estrogens and androgens causes acceleration of growth, to be sure, but coincident with the precocious sexual development there is premature epiphyseal closure, so that the child who at first was taller than his classmates is soon outstripped by them and ends up a stunted adult (Figs. 4 and 5).

Up to this point, it has been shown how, given a normal genetic inheritance, the endocrine glands develop and modify the pattern of somatic and sexual maturation. Brief mention must now be made of other modifying factors, non-endocrine in nature.

Genetic aberrations or mutations affect the sensitivity of the skeleton to growth stimuli. This factor accounts for such diverse patterns of human growth as exemplified by the diminutive African pigmies and the Philippine Negritos (Fig. 6) on the one hand, and the 7 foot African Watusis on the other. In contrast to such entire races, the so-called primordial dwarfs (miniature but otherwise normal individuals) represent sporadic mutations in the human family. Of these, the most celebrated example was Tom Thumb.

Congenital skeletal defects are a frequent cause of growth abnormalities. These defects are often found in association with other abnormalities of the eye, brain, skin, and of the circulatory, gastrointestinal, and genitourinary apparatus. The causes of congenital malformations, such as achondroplasia, arachnodactyly, and ovarian agenesis, are still the subject of much speculation, and the study of teratogenesis, as it is called, has taken on a new importance. Recent work in this field by Duraiswami[8] is throwing some light on the problem. Studying the effects of injecting insulin into fertilized hens' eggs, this worker found that skeletal dwarfing and deformities were produced regularly in the chick as a result of the procedure, but the extent and degree of the abnormalities depended upon the time in development when this influence, as well as other deleterious influences, became operative. When it is recalled that in the human all of the organs and systems are fairly well differentiated by the eighth week of gestation, it is clear that congenital defects must have their origin very early in prenatal life (Figs. 7 and 8).

Other important non-endocrine factors which have to be taken into consideration are neurogenic,

Fig. 5. Male sexual precocity (owing to congenital adrenocortical hyperplasia). Boy, age 6 years, 3 months; height, 52¾ inches; height age, 10 years (average age for this height); bone age, 10 to 11 years. Precocious somatic and sexual development, but marked acceleration of skeletal age will result in premature cessation of growth (Goldberg, M., Clin. Endocrinol. & Metab. 14: 389, 1954. *Reprinted by permission of publisher).* Fig. 6. Genetic dwarfs. Philippine Negrito family. A– Father, age 28 years; B– mother, age 22; C– child, age 8; D– youth, age 18; E– white male, 5 feet, 11 inches tall *(Courtesy Dr. Eugene Eisenberg).* Fig. 7. Congenital skeletal defects. Boy, age 4 years, 3 months (sister on right, age 3 years); height, 35½ inches; height age, 2 years, 6 months; bone age, 2 years, 6 months. Left femur longer than right; head disproportionately large. Mother suffered "nervous breakdown" at time of conception. Child blue at birth; weight 4 pounds, 10 ounces; length, 19½ inches. Fig. 8. Ovarian agenesis (Turner's syndrome). Woman, age 34 years; height, 55 inches; bone age, under 25 years. Note webbed neck, wide chest, lack of mammary development (appearance deceiving because of fat deposits), wide carrying angle, scant pubic hair.

Fig. 5

Fig. 6

Fig. 7

Fig. 8

psychogenic, and nutritional disturbances. Intracranial lesions, particularly in the region of the hypothalamus, may produce effects upon both growth and development. Strangely enough, this type of disturbance, whether caused by neoplasm, infection or degenerative process, may produce retarded growth and development in some instances and somatic and sexual precocity in others (see Fig. 4). Neurogenic precocity, unlike that owing to adrenal or gonadal causes, is true precocity, that is, the reproductive functions, as well as the secondary sex characteristics, are normally, though precociously, developed. From this standpoint, neurogenic precocity resembles so-called constitutional precocity, a diagnosis made only by exclusion.

Nutritional disturbances may result from extrinsic causes, such as inadequate intake of food, as occurs in time of famine, or poor absorption and utilization, as occur in parasitic infestations and avitaminoses. Geographic differences may affect the nutritional value of foodstuffs. This and dietary differences probably account for the fact that Japanese children born and reared in California and the West Coast generally are considerably taller than their contemporaries born and reared in Japan.[9] Nutritional disturbances result also from intrinsic causes, namely, disturbances involving the organs which are charged with the assimilation, transportation, and metabolism and excretion of nutrients essential to the organism for growth. This category includes pathologic conditions of the liver, pancreas, and kidney, or, specifically, such diseases as glycogen storage disease, renal rickets, juvenile diabetes mellitus, and fibrocystic disease of the pancreas. The anoxia associated with some forms of congenital heart disease may also be included here, as well as the psychogenically induced anorexia nervosa. Actually, any severe debilitating disease may reflect itself in disturbances of both growth and development.

One may ask, "What are the practical implications in this analysis of factors affecting growth and development?" Let us re-examine the increment of growth charts (Charts I and II) and see what truths may be found to be self-evident. Note that the curve can be divided into three distinct parts or phases, the early or phase 1, the middle or phase 2, and the late or phase 3. Whereas the influence of nutritional factors and of the thyroid is of vast importance and prevails throughout the entire period of growth and development, each separate phase of growth is under the special influence of an additional factor: the genes in the early phase, the anterior pituitary growth hormone in the middle phase, and the gonadal steroids in the late phase. From this one may conclude that the time of onset of the deviation sometimes gives a clue as to origin. Genetic, congenital, and thyroid disorders become apparent early.

Also, one is impressed by the very large increment of growth which occurs in the early phase. Thus, it may be deduced that disturbances which have their origin early in life during this period of maximal growth may be expected to produce more profound effects than disturbances which originate at a later period. A corollary to this is that the longer such deficits or excesses are permitted to exist, the less time remains available for correcting them, provided, of course, they bear correction.

From this it follows that any aberration of growth and development demands prompt recognition and appropriate therapy. Time is of the essence, since it is axiomatic that the earlier treatment is instituted, the greater the chances of success.

In summary, therefore, it can be said that normal growth and development are the resultants of a carefully integrated genetic and endocrine plan. Deviations may result from many diverse causes. A firm knowledge of the normal relationships assists in the identification of causes of such deviations, in the evaluation of prognosis, and in the selection of appropriate and timely therapy.

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The Psyche and the Skin

THEIR INTERRELATIONSHIPS

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FOR A LONG TIME, physicians have been aware of a group of diseases which lies between the truly organic and the frankly psychotic, but it is only recently that we have made any concerted attempt to understand and treat these so-called "functional diseases." These are the diseases which result from impaired bodily function: the patient has symptoms but has no pathologic changes in tissue to account for his distress.

Such disease is widespread, and it is not limited to the field of general practice.[1,2] All physicians are seeing an increasing number of these patients, and the apparent rise in the incidence of functional disease has been attributed to our highly competitive society and to our general feeling of insecurity.[3,4]

In attempting to understand the origin of functional disorders, it is helpful to remember one fact: basically these diseases depend upon physiologic phenomena. They represent bodily responses to nervous stimuli. For example, we know that fear causes pallor and excessive perspiration, and that apprehension may cause weakness, tremor, and diarrhea. These are definite physiologic responses to emotion, and they are usually fleeting, just as the emotion causing them is fleeting. However, if the emotional stimulus is prolonged, the physiologic response is also prolonged. It is then that we speak of the altered physiology as a functional disease.[5,6]

Recently, a further step in this progression has been proposed: the prolongation of the physiologic change and the altered tissue dynamics which ensue may eventually cause permanent structural disease.[1,7] This is a fascinating concept, for it would appear that thus the psyche alone may produce organic disease. The purpose of this paper is to review the literature on the role of the psyche in the production of various dermatoses. The skin diseases to be considered are eczema, urticaria, pruritus, and pompholyx.

Psychogenesis. Perhaps the first clue to the importance of psychic influences in skin disease was discovered in 1906 when Doswald and Kreibich[8] produced blisters by hypnotic suggestion. Since that time, there has been much conjecture as to the importance of psychogenic factors in skin lesions.

It is a matter of common knowledge that the skin responds readily to emotional stimuli. The reason for this is not difficult to understand, for the skin is richly supplied by a complex vascular network, by innumerable nerve endings, and by various glandular structures, all of which respond promptly to several kinds of stimulation.[9,10,11] Indeed, so sensitive is the skin's response to nervous stimuli that lie detection based upon minute changes in perspiration is of no value because too many extraneous factors will cause false positive tests.[12]

The mechanism for the production of emotional tension is discussed in some detail by Shaffer and Beerman,[13] and by Brunner.[14] For example, if a person finds himself in a situation which produces fear, he will undergo a series of physiologic changes. These include peripheral vasoconstriction, splanchnic vasodilatation, increased cardiac and respiratory rates, sweating, and muscle tension. After these changes occur, there is a profound desire for flight. The normal individual then responds with activity appropriate to the situation: he flees. Since this is a response which alters the environmental influences, the physiologic changes regress and the individual returns to his normal state. However, if flight is not possible, emotional tension is produced by the conflict between the desire to flee and the inability to flee. The physiologic changes concomitant with the original fear are sustained and amplified, and the individual is in a state of emotional tension.

There is definite experimental evidence indicating that psychic tension actually does cause prolonged alterations in tissue dynamics. Masserman[15] produced anxiety reactions in cats and found that they showed persistent physiologic phenomena of the alarm state, and Gantt[16] did essentially the same thing with dogs.

As yet, very little has been done to place the

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urticaria.[35] A variety of methods of treatment may be effective, and some cases seem to clear spontaneously. However, if therapy is to be completely adequate, one must consider allergy, heredity, toxins, and emotional tension as possible contributing factors in the production of this disease.

Pruritus. Pruritus is primarily a symptom, itching. Secondary signs and symptoms are hyperemia, laceration, pigmentation, bacterial infection, and lymphadenitis. Itching is a symptom of many cutaneous diseases, but as a dermatological entity it is simply a sensory neurosis of the skin, without any demonstrable lesion. In these cases, lesions are entirely secondary to scratching.[28]

The importance of psychogenesis in pruritus has been readily accepted.[5,10,26,30,36,38] Klauder[10] was among the first to emphasize its role. Recently it has been reported that functional pruritus perinei is far more common than is generally supposed.[39] MacKenna [24] states that the attacks of itching are subject to exacerbations depending upon alterations in the patient's emotional state or physical condition, and he points out that relief often comes when the skin is torn.

It has been demonstrated that pruritus ani readily causes an eczema which is also associated with intense itching, and it is often difficult to tell which of the two conditions came first.[24] In long-standing cases of pruritus ani, there is a fibrosis of the deeper layers of the skin. This embarrasses the nerve endings enough to perpetuate the disturbance, and irreversible changes may occur.

Numerous psychologic factors have been recognized in the etiology of pruritus. It has been reported that the arteriolar vasodilatation accompanying emotional tension actually increases all inflammatory signs and decreases the itching threshold.[12] Cormia[40] feels that the patient with generalized pruritus is resentful against his entire environment. The sexual implications of pruritus ani, scroti, and vulvae have been suggested repeatedly. The exact role of sexual disturbance has not been determined, but it is known that many times pruritic episodes culminate in sexual orgasm.[9,26,31] Kalz[9] noted that his patients had feelings of guilt, frequently linked with fear of having acquired venereal disease. Nadell[20] reported the significant comment of one of his patients with pruritus: "It makes no difference where I scratch when I itch—it helps."

There are certain rather definite signs of emotionally induced dermatoses.[13] These include: 1) symptoms of pruritus out of proportion to the extent of the dermatitis, 2) presence of a trigger zone which, when touched, sets off a crescendo of itching, 3) itch which develops in crises and paroxysms, 4) utilization of favorite scratch sites, 5) unconscious rubbing of the skin while relating troubles to others, 6) disappearance of the lesion after it is covered with an occlusive dressing, and 7) exacerbation of the dermatitis after probing into the patient's emotional problems.

Treatment of the pruritic patient is difficult, for local preparations simply call his attention to the itchy region. It is for this reason that local therapy used as a placebo invariably causes the symptoms to become worse.[5] However, local application of antihistamines may sometimes give temporary relief.[40] Some physicians have used sedation reinforced by psychotherapy in the treatment of pruritus perinei, their theory being that sedation relieves the scratching, the depression, and the anxiety. Rosenbaum[41] feels that sedation and change of environment are too often simply evasive therapy, and he also warns against the use of local preparations. It is his opinion that treatment of this kind gives the patient permission to stimulate parts of his anatomy that are strongly charged emotionally.

In summary, it seems that a balanced program of local treatment, sedation, and psychotherapy offers the best means of relieving pruritus.

Pompholyx. Pompholyx is a general term describing deep, vesicular eruptions on the palms and soles, more commonly on the former. The primary lesions are deep-seated vesicles filled with clear fluid. They heal by absorption of the fluid and slight exfoliation of the skin. Excessive sweating is nearly always associated with the eruption.[24,26]

Pompholyx was first described as a neurosis by Fox[42] in 1864, and the disease is now generally accepted as having a psychogenic origin.[2,5,30,36,43] Cormia[40] reports that the psychogenic type of hyperhidrosis affecting the palms and soles has been produced experimentally by stimulation of the cerebral cortex in the premotor area.

Wittkower and Russell[2] studied 50 cases of pompholyx among military personnel. They found that 40 of the 50 were emotionally maladjusted, or psychiatrically ill prior to the onset of their skin complaint. Ninety percent of those who were psychiatrically ill had anxiety states. Those termed emotionally maladjusted were equally divided between the hysteric and the obsessional. Thirty of the 50 patients had other functional diseases such as persistent headaches, trembling episodes, and insomnia. Wittkower and Russell concluded that excessive self-love (narcissism) was a common feature in those predisposed to pompholyx. They feel that in view of the hysteric origin of the disease, it is likely that short-term psychotherapy will prove effective in its treatment. Local treatment by roent-

gen ray for palliation has been advocated,[5] but most physicians believe that treatment should be concerned primarily with psychic factors.

General Therapeutic Measures. It has been stated that therapy begins as soon as the doctor and the patient meet,[2,43] for confidence created by a careful history and physical examination is the first essential for the relief of anxiety. Nothing will substitute for the sympathetic ear and understanding attitude of the doctor. Environmental adjustments should be made when necessary, and emotional conflicts exposed, and at least partially resolved, before relief of the cutaneous symptoms can be expected. However, the dermatologist should practice a covering method of psychotherapy, in contrast to the uncovering methods of the psychoanalyst. Covering psychotherapy should reinforce the mature aspects of the personality and should strengthen the forces of repression. It may provide mild ventilation and catharsis in connection with current conflicts, but it must avoid uncovering, penetrating, and extensively cathartic methods. Covering methods include suggestion, physical and mental rest, sedatives, and arousing interest in manual labor. According to Lynch, Hinckley, and Cowan[22] such so-called minor psychotherapy is sufficient to relieve many of the neurodermatoses.

Wright[43] emphasizes the fact that the phobias and neurotic excoriations are deep-seated and should have deep psychotherapy. However, many of the other psychosomatic dermatoses may be handled successfully by the dermatologist or general practitioner. This author feels that if the patient's symptoms can be looked upon sympathetically, if adequate time is allowed for him to pour out his complaints, if honest reassurance is used in discussing his problems with him, and if confidence in the physician is present, the patient will recover in the same length of time whether cared for by the psychiatrist, the dermatologist, or the general practitioner.

Minor psychotherapy is not without danger,[44] for unless great care is exercised, the patient will become too dependent upon the therapist, and the immature aspects of his personality will be strengthened. Another danger lies in the fact that conflicts may be uncovered too quickly and too extensively and the patient may eventually become psychotic. The physician who practices minor psychotherapy should be well acquainted with the power of this therapeutic medium and should not fail to consider the potential damage that he may cause.

With regard to other forms of treatment of these diseases, Frazier and Leeper[45] have found that the injection of epinephrine is the most reliable means of treatment for urticaria and angioneurotic edema. They have also used pyribenzamine® in 150-180 mg. doses with some success. Smith and Hughes[38] report recent trials of histaminase in treating the neurodermatoses. Results have not been striking, but they feel that this is owing to poor dosage regulation. The use of gradually increasing doses of histamine in an effort to desensitize the patient has also been tried, and merits further investigation. Sternberg and Zimmerman[18] report success with the use of cortisone in these diseases.

The treatment of the neurodermatoses is thus largely a matter of fitting the individual patient's needs, and no single method of therapy will give uniformly good results. These diseases have many causes, and successful therapy must embrace all possible etiologic factors. There is little doubt that some form of psychotherapy is needed in nearly all cases if a lasting cure is to be effected. It is important to realize that the attending physician can furnish such psychotherapy himself, and thus he may increase greatly the breadth of his service to his patients.

Summary

The importance of functional disease has been stressed, and the mechanism of producing prolonged alteration in tissue dynamics has been outlined. The role of the psyche in the production of structural disease is mentioned, and evidence is presented which demonstrates the close relationship between the psyche and the skin. Four dermatological conditions which have strong psychic components are discussed, with primary emphasis placed on causative emotional factors. These diseases are eczema, urticaria, pruritus, and pompholyx. General therapeutic measures are mentioned at the close of the paper.

Conclusions

No one would question the close physiologic relationship between the psyche and the skin. However, we are rather hesitant in accepting the fact that there may also be a pathologic relationship between the two: that prolonged emotional stimuli with their concomitant physiologic changes may actually produce structural changes in the skin. Detailed case studies seem to confirm the importance of such psychogenic factors in some of the dermatoses. It has therefore been postulated that therapy cannot be totally effective unless some form of psychotherapy is used in conjunction with more conventional forms of treatment. The psychotherapy needed for these patients is not beyond the scope of the general practitioner, and he should use minor psychotherapy as readily as he uses minor surgery.

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The Child with Cerebral Palsy and His Family

Edith Meyer Taylor, Ph.D.

GROWING INTEREST IN CEREBRAL PALSY has been promoted throughout the country, and an increasing number of facilities have been established in many communities to take care of patients. Cerebral palsy centers, clinics, and workshops enable the general practitioner and the pediatrician to refer their cerebral palsied patients to specialists. Usually the cerebral palsy clinic supervises treatment, education, and rehabilitation, leaving the referring physician with only the care of acute medical needs ranging from feeding problems and colds to infections or convulsions. Such a division of responsibilities works in general satisfactorily enough. The patients get expert help and advice, and the practitioner has the security of shared responsibility in a relatively unpromising medical situation.

If he continues to take care of the family, the physician soon realizes the complexity of human problems which are directly or indirectly the results of cerebral palsy in the family. He often comes to feel that many of the efforts to help the patient do not always take enough account of the emotional stresses that are created around the palsied child. Successful management of the case becomes, however, almost impossible if these conditions are not fully recognized.

The following psychologic reflections in this direction grew out of close contact with many families with children with cerebral palsy.

In spite of variations in motor deficiencies and in environmental influences, the situations of children with cerebral palsy have many factors in common that are distinguished from those of normal children. From earliest babyhood on, the condition of these children has striking effects on their parents. While the healthy baby delights his parents with new accomplishments, the handicapped child becomes often quite early the source of disappointment. Even when his disability is not recognized early, the slowness of his progress creates apprehension. The young mother who quite recently had dreamed of marital romance and motherhood, finds too suddenly that she has a child she cannot be proud of. She must admit to herself that she cannot take part whenever her friends talk about the development and progress of their babies. Depending on her temperament, she becomes resigned and depressed or defensive and rebellious. In either case, she no longer is a cheerful member of her group.

Often a young mother of a cerebral palsied child leads a lonesome life. She may never leave her child to the care of others because she is afraid that the child may not eat well when inexpertly fed, or may get hurt while being changed, or not be comforted when he is crying. She then is criticized for overprotecting the child. Her solicitous attitude is explained by catch words such as "guilt" and "rejection." There is no doubt that her fears may stem from deep-seated and complex anxieties. But also it should not be overlooked that she is dealing with a desperate and often not recognized reality situation. Many damaged babies have defective swallowing mechanisms, are difficult to feed, and may choke when upset. Often they are awkward and stiff to lift and dress. Cuddling is frequently uncomfortable and

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unrewarding. The care of some palsied children, no matter how conscientiously or efficiently it is done, often does not provide the emotional and sensual satisfactions that are the basis of healthy mother and child relationships.

A father's role in young children's lives is too often minimized. Any good observer of modern families knows how intensely most fathers partake in the care of babies. In a family with a child with cerebral palsy, the father's life is necessarily much affected. Even more than his wife, he has a firm preconceived idea of what he would like "Junior" to be. He may have had an image of masculine qualities and is cruelly disappointed with a baby boy who is lacking in motor power and who is, when older, still dependent and oversensitive. If he wanted his son to show intellectual abilities and competitive spirit, he may find him to be dull and unenterprising. Frequently he is only able to admit disappointment after much struggle, wear, and tear for both the child and himself. Psychologically, it may be understandable why fathers in general seem to be more indulgent, more affectionate, and less defensive with their cerebral palsied daughters than with their sons, though there are, of course, many exceptions to this.

Relationships between the parents of cerebral palsied children are also influenced both by subtle and by obvious factors. The young couple that hoped for a promising and serene future is faced with a problem for which there is no ready-made solution; it will demand every kind of sacrifice and will be with them for the rest of their lives. While in some cases the parents become more attached to each other because of their common fate, the strain often breaks up relationships that were more tenuous from the start. Everyday life is much affected; often there is no recreation or freedom for father and mother together because one of them always has to stay home. The husband sees his wife get overtired and strained; both get up at all hours to look after the baby. Many couples are afraid of having more babies, either because of the amount of care and expense involved or because they are afraid that "it might happen again." Many people continue, regardless of medical explanations, to be afraid of some hereditary factor. In cases where the Rh factor was recognized as the cause of cerebral palsy, some partners susceptible to doubts start to wonder what other incompatibility might be lurking.

In many families, the presence of younger or older children introduces new aspects. This may, depending on the case and the family, make things either more difficult or easier. In many families, the presence of other healthy children provides an excellent equilibrium. The child with cerebral palsy can then be given the proper amount of affection and loyalty; in many cases he profits from the additional and natural warmth that normal family life creates. However, many families can never develop a reasonably serene attitude; often the handicapped child in the midst of a healthy family becomes the special and exclusive center of attention and thus deprives his siblings. Some brothers and sisters become independent earlier than normal; some in self defense develop into rather forceful egoists. More often, however, there are times when the healthy siblings wish that they could be sick and dependent too. They find their mother too occupied with their afflicted brother; frequently they have to take care of themselves while the mother patiently and conscientiously makes endless trips to clinics and doctors. If they express their jealousy and annoyance, occasionally they are even urged to reflect on their good fortune at having healthy limbs and a good mind. Some brothers and sisters come to hate themselves for being well, some develop guilt feelings and other psychologic disturbances. Their role not only at home but also outside is influenced by their special family situation. In many cases, the well child feels that he has to defend his palsied sibling against others; he takes his side fiercely against any possible criticism and abuses in the neighborhood. Sometimes he may display him proudly, at other times he may try to hide him and does not invite his friends to the house. Whatever his attitude, his social development becomes affected in some way.

Besides the members of the immediate family, the emotional climate in many homes is influenced considerably by neighbors and relatives. A normal family's troubles and problems might pass unnoticed for some time in many communities. However, a child that does not develop normally becomes very quickly conspicuous. Well-meaning but hard to deal with attitudes of in-laws and neighbors add new complications. Such attitudes may vary from polite and embarrassed silences to urgent requests to do something. Once the child is known to be handicapped, casual visitors no longer just drop in because they do not want to appear nosy. Grandmothers or independent relatives try to help either with the palsied child or with the well children. This is frequently a good and natural solution, but it creates new problems around the house when, for her services, a grandmother quite naturally demands her share of authority and affection.

What then is the emotional development of the cerebral palsied child himself who arouses and grows up among such a complex set of feelings? Almost everybody agrees that any child's adjustment to the outside world is dependent on the emo-

tional climate that surrounds him. Healthy growth has been described as growing independence. Its development starts early, as soon as the baby becomes able to roll or creep away from where his mother last put him. He finds that she usually approves and encourages his enterprises. He learns to cope with other places and other people, and becomes secure in the outside world when his mother trusts him away from her immediate supervision and welcomes him back. Uncertainty and apprehension at home makes many children timid in their contacts outside. The same principles necessarily apply to the child with cerebral palsy who frequently is held back by fears around him. Often one hears in this connection lack of motivation mentioned as the only explanation for passivity and lack of enterprise. While this may be a factor, in many cases it oversimplifies the problems involved. It is essential to give serious consideration to the direct consequences of the physical factors that stunt the normal process of growing independence in children with cerebral palsy. These factors intervene in many ways and obviously to a different extent depending on each patient's particular situation.

A hemiplegia, for instance, may in its mild form seem only a minor handicap in a young baby; but since manipulation of objects is essential for his growing comprehension of the world around him, a stiff hand becomes a serious impairment. He remains dependent on outside help longer than normal, a disadvantage often reflected in the development of his personality.

In the severely palsied child, all difficulties are multiplied. His inability to get hold of and to touch and retain objects robs him of countless experiences of touch and close range investigation, and is reflected in his practical comprehension as well as in his language development. The child who cannot get around by himself remains for a long time anchored to one place and one unchanging view. The older and heavier he gets, the less he is moved about. Some palsied children hardly ever see their own kitchen, basement, or attic or their neighbor's yard. They often seem content enough in their inactivity and show no signs of curiosity. Some children, on the contrary, may, when they finally acquire some form of locomotion, appear hectic and superficial; they seem to be attracted by one thing or another in their environment and are intent on reaching it, driven by a singularity of purpose and totally unaware of what is in their way. The resulting falls or upsets frighten those around them. Even with a most devoted but necessarily anxious family, a child with cerebral palsy attracts more smiles and signs of affection by sitting or lying quietly than by spurts of activity which, through his awkwardness, may lead to mishap, disturbance, and embarrassment.

The normal preschool child plays imaginatively, imitates others, asks questions, and expresses his views. He learns from these activities. Many children with cerebral palsy do none of these things spontaneously. They are intent on grasping, holding, and steadying objects. This demands much effort and remains the only goal in games while organization and creative activity are missing.

Many of our patients remain unaccustomed to expressing themselves, either in play or in verbal communication, for various reasons. Often sound and speech production are either impaired or, in early years, nonexistent. Auditory difficulties may add other complications. In many cases, well-meaning parents discourage the child's expressing himself by gestures, hoping by doing so to further language development. In children with dysarthria, attempts at speech production are often painful to watch and to listen to. Their wish to express themselves is inhibited when they sense their onlookers' distress and frustration. Lack of communication, even on a pre-language level, seems often characteristic of children with brain injury. Many of our patients are slow in learning to use signs or symbols to express themselves. They show their feelings in immature ways such as by easy crying or laughing. Even when there is no specific difficulty as such, language is frequently a repetition of learned phrases and words used at appropriate times, often with great skill. But it is less often based on concepts or used for communication of ideas.

Restricted means of interpersonal relationships, a limited sphere of living, and a tendency to get fatigued by effort and confusion often reduce the social contacts of the palsied child to a very few people. Being unfamiliar with outsiders, he remains apprehensive and aloof with strangers, like a very young child.

The normal child learns early in life how to take his role in a society of contemporaries. He learns the advantages of co-operation, self-sufficiency, and diplomacy. He becomes aware of others and learns to live with them from his play pen days on. The child with cerebral palsy, whether the disease is mild or severe, enters into such learning situations on unequal terms, if at all. He is at best indulged by others, at worst teased or frowned upon. He remains different and special and hardly ever becomes a member of a group on reciprocating terms. The stage of immature egocentricity is necessarily carried far beyond the usual age level. The palsied child's special circumstances keep him dependent

on his family and their feelings longer than is the case with a normal child.

The preceding remarks try to point out some of the many factors that influence the emotional condition of the child with cerebral palsy. It is obvious that there are many variations and degrees. In a fair number of children with cerebral palsy, the situation is less dramatic, and emotional difficulties less important or perhaps non-existent. However these are the exceptions. As these successful children and their families are studied, an almost uniform pattern is seen. In the first place, the parents and the rest of the family accept the difficulty without allowing it to diminish the warmth of their feelings. The disability is socially acceptable and is not of a type which limits activity or impairs mental development, or interferes with speech. Under these highly favorable circumstances, stresses may not arise. Also now and then a conspicuously handicapped individual may have so much serenity and charm that all rules are invalidated. The occasional occurrence of successful adjustment does not throw any doubt on the emotional difficulties that most of the children have to cope with.

Cerebral palsy is a family problem and has to be treated as such. Neither medical, psychologic, educational or socio-economic considerations by themselves can lead to understanding and effective handling. All of them have to be combined into one intelligent, sympathetic, and realistic approach.

This viewpoint is obviously not a new one. It has been advocated and practiced for many years by, among others, Dr. Bronson Crothers. When faced with the magnitude of practical problems involved, more and more of the younger workers in the field are going in the same direction.

WOMAN'S MEDICAL COLLEGE COMMENCEMENT—1955

The Woman's Medical College of Pennsylvania extends a cordial invitation to all members of the American Medical Women's Association to attend the commencement exercises in the Irvine Auditorium at Thirty-Fourth and Spruce Streets, Philadelphia, on Friday, June 10, 1955, at 11:00 o'clock. Dr. William C. Menninger will be the commencement speaker.

AMWA members are also invited to visit the College when they are in the Philadelphia area. The "A" bus north from the center of the city goes directly to the College doorstep and provides an inexpensive way to get there.

World Health Organization

THE EXECUTIVE BOARD of the World Health Organization ended its fifteenth session under the chairmanship of Dr. Henry van Zile Hyde of the U. S. Public Health Service, with a recommendation to the World Health Assembly to accept the Director-General's proposals for the Organization's 1956 programme and a budget of $9,612,000.

This represents an increase of $111,600 over the current year's budget of the Organization in order to cover certain costs of field projects so far supported in part by the governments concerned.

The Executive Board found that the 1956 programme, which will be submitted to the World Health Assembly in Mexico City in May, follows the guiding lines of WHO's Four Year Plan. Direct assistance will be given to over 100 countries and territories to help them develop their health services with particular emphasis on sanitation, control of disease, education of health staff, mother and child health, and so forth. In this respect, the Executive Board noted with satisfaction that wider public health projects are replacing more and more the single purpose type of field project. Campaigns against single diseases are planned increasingly as a part of a comprehensive public health service.

The other main function of WHO, that of providing certain health and medical services of a world nature, will be developed further in 1956. It includes sanitary regulations to prevent the spread of diseases through international movement of travellers and goods, development of health statistics, and standardisation of drugs.

The WHO Executive Board took a series of important decisions on other matters including the following:

Atomic Energy. WHO is to give first priority to the health protection of populations against atomic radiation in its new programme dealing with medicine and public health in relation to atomic energy.

Malaria. In view of the fact that certain types of malaria-carrying mosquitoes are already showing resistance to insecticides, all threatened countries should be urged to plan total malaria eradication before it is too late.

Dental Health. WHO is to appoint a dental health officer to guide its international dental programme of research, prevention, and education.

Food. In view of the potential health danger from the increasing number of chemical substances added to various foodstuffs, WHO and the UN Food and Agriculture Organization are to call a joint conference of experts on food additives.

Gifts. WHO has been presented in the past year with gifts from individuals, amounting to several hundred dollars, and has received from the Government of Brunei a donation of $3,250. These were accepted with gratitude by the Board.

World Health Seals. These seals have been put on sale by various governments but only a small number of countries have participated in the programme. It will be discontinued after 1955.

Organizational Study. A special study on the integration of preventive and curative medicine in public health programmes, with special reference to the role of hospitals, is to be carried out.

Health Assembly. Negotiations are continuing on arrangements for holding the Health Assembly in Mexico City, and the Board expressed again its gratitude to the Government of Mexico.

* * *

Medical libraries throughout the world, which previously offered their surplus publications to other medical institutions for free distribution and exchange through the United Nations Educational, Scientific and Cultural Organization, will now offer them through the World Health Organization, Geneva, the two United Nations agencies have announced.

WHO will inform medical libraries in its member states of the availability of medical books and periodicals offered by libraries. It will not itself collect and make shipments but will act as a central information service for medical libraries wishing to exchange and distribute material.

All shipments of publications will be made directly from one medical library to another after agreement has been reached on the items required and on the question of transport costs.

WHO, through its library and reference section, is already in touch with many medical libraries throughout the world, but it announced that it would be glad to receive from additional medical libraries offers of exchanges, accompanied by lists of the most needed books and periodicals.

NOMINATIONS

The Nominating Committee presents the following nominations for the year 1955-1956:

President-Elect—CAMILLE MERMOD, M.D., 15 Washington Street, Newark, New Jersey.
First Vice-President—JEAN GOWING, M.D., 602 Leverington Avenue, Philadelphia, Pennsylvania.
Second Vice-President—EDITH PETRIE BROWN, M.D., 441 Turney Road, Bedford, Ohio.
Recording Secretary—CLEMENTINE E. FRANKOWSKI, M.D., 1907 New York Avenue, Whiting, Indiana.
Corresponding Secretary—RUTH HARTGRAVES, M.D., 1407 Medical Arts Building, Houston, Texas.
Assistant Treasurer—MARY MARGARET FRAZER, M.D., 76 W. Adams St., Detroit, Michigan.

REGIONAL DIRECTORS

New England—CLAIRE F. RYDER, M.D., Rice Island, Cohasset, Massachusetts.
North Atlantic—REBECCA P. RHOADS, M.D., 416 Chichester Lane, Wynnewood, Pennsylvania.
MARCELLE BERNARD, M.D., 635 E. 211th Street, New York, New York.
South Atlantic—R. CHARMAN CARROLL, M.D., 406 Montford Avenue, Asheville, North Carolina.
Northeast Central—MARGARET STANTON, M.D., 5625 West Division, Chicago, Illinois.
Northwest Central—RUTH F. WOLCOTT, M.D., Spirit Lake, Iowa.

HELEN F. SCHRACK, M.D., *Chairman*
DOROTHY ATKINSON, M.D.
AMEY CHAPPELL, M.D.
BEULAH CUSHMAN, M.D.
BEULAH SUNDELL, M.D.

PROPOSED CHANGES

Constitution and By-Laws

The following additions to the By-Laws were approved by the Board of Directors at the Mid-Year Board Meeting November 1954 in Atlanta. Final action will be taken at the Annual Meeting June 2 through 5, 1955, in Atlantic City.

BY-LAWS

ARTICLE VII. Finances

(New) **Section 6a. Interest from Life Membership Fund.** All interest from the Life Membership Fund shall be transferred annually to the General Fund.

(New) **Section 6b. Capital of Life Membership Fund.** Use of any of the capital of the Life Membership Fund shall require action of the Board of Directors.

ARTICLE V. Committees

(Addition to) **Section 1. Standing Committees**
(e) *(New)* (17) Constitution and By-Laws

(New) **Section 22. Constitution and By-Laws.** It shall be the duty of this committee to recommend revisions, and to study proposed amendments to the Constitution and By-Laws for wording and legality before presentation of said amendments to the membership for vote. Members of this committee shall be appointed on a rotating basis.

(Renumber) present Section 22, 23, and 23 as 23, 24, and 25 respectively.

American Medical Women's Association

PRESIDENT'S MESSAGE

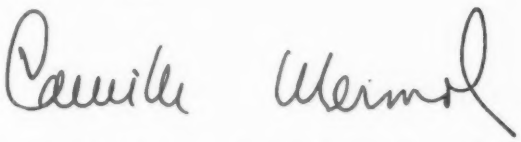
ALL OF US RECEIVE APPEALS for support from organizations too numerous to name. It is undoubtedly true that they all do important work for various types of diseases. The money contributed helps both in the care of patients and in the furthering of research work. With the increasing longevity of our general population, a greater percentage than ever before of the people are in the age where degenerative and neoplastic diseases are more prevalent.

Of the organizations which are active in this field, the American Cancer Society does outstanding work. All of us can further their efforts by working actively with this society and by making our offices teaching centers for our patients.

It is almost superfluous to remind you that the control of many of these diseases of old age depends on good physical examinations. Just recently a speaker told us that the words "thorough physical examination" were redundant. I do hope he is correct, but sometimes am not absolutely sure of it.

Another piece of mail has reached your desk recently: the 1955 edition of our Directory of members. It represents much hard and accurate work by the Secretariat at 1790 Broadway. We are proud of it and thank them for their diligence.

Are you coming to Atlantic City in June for the Annual Meeting?



P.S. Urgent: If you have not answered the questions regarding the terms of office of your officers, please turn to advertising pages 28-29, and send your answers at once to the AMWA office at 1790 Broadway, Room 409, New York 19, New York. Corrections for Membership Directory, advertising page 35.

ANNUAL MEETING
June 2-5, 1955
Hotel Dennis, Atlantic City, N.J.

Thursday, June 2

9:00 a.m.—Registration—Lower Lobby
9:00 a.m.—Publications Committee — Board Room
11:00 a.m.—Finance Committee—Art Studio
2:00 p.m.—Executive Committee Meeting — Board Room

Other committee meetings as arranged by the chairmen

Friday, June 3

9:00 a.m.—Registration—Lower Lobby
9:30 a.m.—Board of Directors—Board Room
10:30 a.m.—General Session—Garden Lounge
12:30 p.m.—Luncheon—Ozone Suite
3:00 p.m.—General Session—Garden Lounge
7:30 p.m.—Woolley Memorial Lecture — Ozone Suite

Saturday, June 4

9:00 a.m.—Registration—Lower Lobby
9:30 a.m.—General Session—Garden Lounge
12:30 p.m.—Luncheon—Ozone Suite
3:00 p.m.—General Session—Garden Lounge
7:30 p.m.—Inaugural Banquet—Ozone Suite

Sunday, June 5

9:30 a.m.—Executive Committee Meeting — Board Room
10:30 a.m.—Board of Directors Meeting — Board Room

(If you have not already done so, please fill out the following forms: Room Reservations—advertising page 37, Meal Reservations—advertising page 42.)

REPORTS FROM COMMITTEES

ON REINSURANCE

THE CONTROVERSIAL REINSURANCE BILL was formulated by its proponents in order to give active support to voluntary health insurance and carry out the President's health objectives . . . "to search out by appropriate means, recommend, and put into effect new methods of achieving better health . . ." (J.A.M.A. **156:** 1507, Dec. 18, '54). To review, the bill proposes:

1. To authorize the Secretary of Health, Education, and Welfare to conduct studies and collect and disseminate information concerning the organizational, actuarial, operational, and other problems of health service prepayment plans and their carriers. This information would be distributed upon application and without charge.

2. The bill would authorize the Department of Health, Education, and Welfare to issue a form of reinsurance to voluntary health service prepayment plans. According to the bill, the reinsurance would be issued where needed, to "stimulate the establishment and maintenance of adequate prepayment plans in areas, and with respect to services and classes of persons, for which they are needed." (from Dr. George F. Lull's letter to Congressman George Aiken, July 12, '54)

Reinsurance is the system of pooling insurance risks. One company insures its clients; then it, in turn, is insured by one or more other companies in order that the loss may be spread, and no one company suffers unduly through a catastrophic loss.

Co-insurance is another feature included in this bill, meaning that the insured takes part of the risk up to a predetermined amount, thus lessening the liability of the insuring company.

Secretary Oveta C. Hobby, in her speech before the AMA House of Delegates November 29, 1954, stated that the following elements must be present to achieve the President's objective: 1) the means must be compatible with the high professional standards of the medical profession; 2) the principle of free choice of physician by patient must be preserved; 3) the patient-doctor relationship must be preserved; 4) any legislation should be compatible with the concept of voluntary insurance; and 5) the means must be true to the American principle of opportunity for self help.

Secretary Hobby believes that the reinsurance plan is the only way to achieve these five aims, and that, in addition, the voluntary health insurance companies would be aided in extending the coverage and benefits of their insurance. She also stated that the reinsurance plan would not benefit the approximately 30 million uninsurable persons, the medically indigent, the chronically ill, and those already hospitalized or institutionalized. This group would still have to be reached by private, or local, county or state welfare programs. (J.A.M.A. **156:** 1506-1508, Dec. 18, '54).

On January 5, 1955, HR400 was introduced into the House; this bill is a reprint of HR8356, the resinsurance bill which was sent back to committee by the Eighty-Third Congress last year. (HR400 is very similar to No. 3114, the old Senate reinsurance bill).

The setting of minimum standards is objectionable to many. As soon as federal money is involved, federal control follows in spite of all assurances to the contrary. The Secretary of Health, Education, and Welfare is given very broad powers under the bill: . . . "to make such regulations as he may deem necessary to carry out the purposes of this Act." The bill states "Except as may be specifically provided for in this Act, nothing in the Act shall be construed to authorize the exercise of any supervisory or regulatory control over any carrier, or over any hospital or other health facility or personnel furnishing personal health services covered by a participating health service plan." (Sec. 107 (b) "Challenge to Socialism," **8:** 2, March 18, '54). Personnel means doctors, nurses, dentists, and so forth. But the secretary is also authorized by the bill to issue regulations stating the means by which a company is enabled to obtain federal reinsurance. The secretary may specify by regulation "minimum ranges of health conditions to be covered by the plan, minimum provisions as to the kind, quantity, and duration of health services to be covered or provided under the plan, and safeguards against undue exclusions of health services or health conditions from coverage or against undue exclusions

or limitations." (Sec. 303 (a) (2). "Challenge to Socialism," **8:** 3, March 18, '54).

From the above section, it is clear that the regulations could force a company to insure the obviously uninsurables, the destitute, the chronically ill, and the aged, in order to become eligible for federal reinsurance. These policies would cause a loss to the company thus forcing it to draw on the federal reinsurance fund. According to Mr. Edwin J. Faulkner, president, of the Woodmen Accident and Life Company, this would have the effect of driving private reinsuring companies out of business, and forcing the carriers to take on the uninsurables, with the inevitable result that the taxpayers would be furnishing care for the indigent in the form of subsidy, actually charity. Mr. Faulkner contends that there is no need for reinsurance from a federal fund.

Private companies can cover the need adequately. Reinsurance according to Mr. Faulkner: 1) does not increase the ability of the insurer to sell protection to the unwilling buyer; 2) does not reduce the cost of insurance; 3) does not make insurance available to any class of risk or geographic area not now within the capabilities of the voluntary insurers to reach; and 4) could not increase voluntary health plans any more rapidly than is now being done.

Other objections to the bill from the standpoint of an experienced insurance man are that: 1) pressure would be exerted to demand subsidies when the losses sustained became too great; 2) there is too broad a delegation of power to the executive branch of the government, and too little specific outlining of the plan; 3) to the extent that the federal reinsurance plan is operative, state supervision of insurance is superseded; and 4) insurers availing themselves of the plan would be subject to government regulation of premium rates. This would remove the competitive features of the health insurance business, and limit flexibility of premium rates. (Faulkner, E. J., J.A.M.A. **156:** 1508, Dec. 18, '54.)

The AMA is in complete accord with the purpose of the bill which is to promote the best possible medical care on reasonable terms. However, it doubts that this bill is either needed at this time, or that it would solve the problems. According to Dr. F. E. Wilson, Director of the Washington office of AMA, the basic objections to the bill are:

1. There is a very definite question as to the need of government intervention in the insurance field at this time. The combined assets of the insurance companies offering health reinsurance facilities amount to approximately two billion dollars.

2. The growth of prepayment voluntary health insurance has been extremely rapid. At the present time, at least 92 million people out of a total insurable population of 130 million have some form of protection. This fact plus the demonstrated ability of the insurance agencies to meet the needs and demands of the people indicates to us that it is not necessary for the Federal government to enter the field of health insurance.

3. Reinsurance will not overcome the inertia of the unwilling buyer unless the government provides a subsidy for the purpose of selling insurance at a price below the cost of servicing the contract. This, we believe, would be objectionable.

4. Reinsurance does not provide a means of making insurable what would otherwise be an uninsurable risk.

5. Reinsurance does not reduce the cost of insurance unless subsidy is introduced. (Letter to Honorable H. Alexander Smith, United States Senate, Washington, D.C., from Dr. F. E. Wilson July 8, 1954, stating AMA stand on reinsurance).

The President will request $25 million to start a reinsurance fund for voluntary health plans. The fund's capitalization is authorized at $100 million, and the Administration will also request $20 million to improve medical care of public assistance recipients. It behooves all of us to study the implications of this bill since such a tremendous government expenditure is involved.

In conclusion, a change in type of reinsurance is apparently not needed at this time. Reinsurance as proposed would be another wedge toward federal control of health insurance and indirectly of medical practice, by virtue of the fact that the government would set minimum standards and regulate and specify eligible companies. This legislation would put medical practice and medical policies under the domination of lay boards of labor and management.

RUTH ELLIS LESH, M.D., *Chairman*
Legislative Committee

NEWS FROM THE BRANCHES

Branch Eleven, Southwestern Ohio

A joint dinner meeting of the Cincinnati Medical Women's Club was held with the Cincinnati women lawyers on January 25, 1955. The speaker was former Judge Edward L. Dixen.

ESTHER POHL LOVEJOY, M.D.

DR. ESTHER POHL LOVEJOY was born in Washington, reared in Portland, and worked her way through the Medical School of the University of Oregon by clerking in Portland department stores. She was the second woman to graduate in medicine there, and the first to practice. She afterward attended the West Side Post Graduate School in Chicago, and did graduate work in Vienna. Soon after graduating from the Oregon Medical School, she married Dr. Emil Pohl. In 1897, she and her husband and her brother, all in their twenties, were in the forefront of the gold rush to Alaska. Her husband and her brother lost their lives there.

From 1905 to 1909 inclusive, Dr. Esther Pohl (Lovejoy) was a member of the Portland Board of Health, and from 1907 to 1909 was head of the department, the first woman doctor in the United States to hold such a post. During this period, she made local headlines by launching a campaign against rats, the carriers of bubonic plague which had appeared in San Francisco, and for which no protective serum had been found at that time. She also wrote the first milk ordinance to pass the Portland City Council, and introduced school inspection into the city schools. In this work, she had the strong support of the Portland women's organizations and the city and county medical societies.

In 1917, the President of the American Medical Women's Association, Dr. Bertha Van Hoosen, named a War Service Committee for the purpose of organizing the women physicians of the United States for service in this country and in Europe. Under the auspices of this group, Dr. Lovejoy served with the American Red Cross in France in 1917, investigating the war needs of women and children. During 1918, she toured the United States, reporting on her findings and telling the American people of the great need of the Red Cross in Europe. The War Service Committee became the American Women's Hospitals in 1917, and in 1919 Dr. Lovejoy was named chairman of its executive board, a position she has held continuously ever since.

For her work in Europe during and after World War I, Dr. Lovejoy has been decorated by five nations. She holds the Cross of the Légion of Honor of France; the Cross of the Redeemer, the Grand Cross of the Order of King George I, and the War Cross of Greece; the Cross of the Holy Sepulcher of Jerusalem; the Gold Cross of Saint Sava of Yugoslavia (Serbian); and the White Russian Red Cross of Constantinople. Dr. Lovejoy has given these decorations to the library of the University of Oregon Medical School, where

(Continued on following page)

they are on permanent display. Among other honors, she has been made an honorary member of the British Federation of Medical Women, she has received an honorary degree of Doctor of Public Health from the Woman's Medical College of Pennsylvania, and, in 1942, an honorary degree of Doctor of Laws from the University of Oregon.

In memory of her husband, Dr. Pohl, and her son, Frederick Clayson Pohl, Dr. Lovejoy has established a scholarship fund for medical students, one third of whom should be women, at the Medical School of the University of Oregon. Her original gift has been augmented by her each year until the endowment now totals over $30,000. Recently, she was made the first lifetime honorary member of the Medical School Alumni Association, by special action of the alumni officers. In one of his first actions as alumni president, Dr. Merl L. Margason wrote Dr. Lovejoy announcing "a new policy whereby outstanding members of the Alumni Association who have contributed substantially to medical education are made lifetime honorary members. We appreciate the contributions you have made to medical education in general and to our Medical School in particular. The Dean has informed us of the many students you have helped through your scholarships —a real tribute to the confidence you place in your Alma Mater."

Under Dr. Lovejoy's direction, the American Women's Hospitals Service aided the refugees of the Greco-Turkish War. Dr. Lovejoy's book, "Certain Samaritans" (Macmillan), relates the work of the service among these refugees. She has also written "House of the Good Neighbor" (Macmillan). At present, she is working on a definitive history of modern medical women.

Dr. Lovejoy was one of the founders, and the first President of the Medical Women's International Association, holding this position from 1919 to 1924. She was President of the American Medical Women's Association from 1932 to 1933. In 1951, she was the recipient of the Elizabeth Blackwell Medal, given annually by the American Medical Women's Association for "outstanding contribution to the advancement of women in medicine."

In telling Dr. Lovejoy that she had been chosen Woman of the Year by Branch Five, Portland, Oregon, Dr. Miriam Luten wrote: ". . . we all agreed we would nominate you as the woman doctor from the Northwest who should be recognized. . . . We sincerely hope that you will agree with us that you are still a Northwesterner."

The American Medical Women's Association joins with Branch Five to honor Dr. Lovejoy, and salutes her as its First Lady.

THESE WERE THE FIRST

Dr. Catherine Lindsay, of Scottish ancestry, was born in Madison, Wisconsin, and graduated at the New Jersey Trall Institute in 1876. She was one of the first women on the staff of the Battle Creek Sanitarium, and was the first to suggest the use of the electric light bulb in the application of heat. Later, Dr. Kellogg developed the electric light cabinet. Dr. Lindsay was interested in the training of nurses and in physiotherapy. She spent four years in Cape Town, South Africa.

Dr. Millie Wilson, graduate in 1903 from the Michigan College of Medicine, served 41 years on the staff of the Lapeer State Home and Training School in Rochester, Michigan. Dr. Wilson was the first woman to drive an automobile in Lapeer county, secured her student license to fly and to solo, and had a fondness for motor boating.

Dr. Thelma G. Harmon was the first woman doctor in the Twelfth Naval District to join the Navy, and was commissioned a Lieutenant, junior grade, in the Medical Corps (Woman's Reserve). She graduated from the University of California Medical School in 1921, and has practiced in San Francisco, California.

Dr. Mildred Fay Jefferson was the first Negro woman to graduate from the Harvard Medical School, June 1951.

Dr. Nettie G. Parrette, of Robbinsville, North Carolina, was the first recipient of *Mademoiselle.* magazine merit award. She received this in December 1942, for practical patriotism.

Dr. Mary Frances Nawrocki was the first woman to receive a medical degree from the St. Louis University School of Medicine, in 1952, and was the first woman tapped by Alpha Omega Alpha, honorary medical society.

—Elizabeth Bass, M.D.

ALBUM OF WOMEN IN MEDICINE

MARY ELIZABETH BATES, M.D.

Dr. Mary Elizabeth Bates, a generous friend of the AWH and a contributor to the Scholarship Loan Fund, was born at Manitowoc, Wisconsin, on February 25, 1861, and died at the age of 93 at Denver, Colorado, where she had lived since 1891.

Dr. Bates was one of our outstanding pioneers. She was a student at the Woman's Medical School (Northwestern University), Chicago, where she took her examinations for an M.D. degree successfully in 1881, when she was 20 years of age; and was awarded a diploma the following year, four days after she attained her majority.

Meanwhile, she had won an appointment to an internship at Cook County Hospital, the first woman to hold that position. A friendly professor who knew all the tricks of the trade said it was her youth and inexperience that gave her the courage to take that job. Her initiation was more than anticipated, but she was such a good worker and such a good sport that prejudice among her fellows gradually faded away and she was accepted not only by the other interns, but by the nurses (untrained), many of whom were old enough to be her mother.

Warned of the pranks of medical students, Dr. Bates had kept her door carefully locked during the early nights of her internship, but after she became one of the hospital family this precaution was neglected; and in 1822, when she was 21 and just before she finished her service, her room was invaded by the "gang" and she was lifted forcibly from her bed, curl papers and all, and carried on a stretcher to the surgery where interns and nurses had assembled and a feast was spread in her honor.

Among the interns, she was second to Dr. Frank Billings, which turned out to be no small distinction. She afterward studied in Heidelberg and Vienna, and from 1885 to 1890, before she was 30, was professor of anatomy at her alma mater. But her health was not good, and in 1891 she moved to Denver, Colorado, where for several decades she participated in social welfare activities and promoted the passage of laws for the protection of women and children.

In 1926, she attended the meeting of the AMWA at Dallas, Texas, and introduced an associate who gave an account of the development of oil fields near Amarillo in the Panhandle, and offered the delegates a trip to the district. Dr. Bates had inside information regarding this matter and wanted to share her impending good fortune with her professional sisters. But a trip to old Mexico at their own expense was more attractive. At a later date, Dr. Bates gave 10,000 shares of oil stock to the AWH Committee, which she said would pay 10 pecent on a valuation of one dollar per share. This was was underestimate. That stock has paid 20 percent for many years.

In October 1953, the American Humane Association paid her tribute in a special resolution naming her "outstanding humanitarian of the year" for what it called "a lifetime of noble devotion to advancement of the humane cause."

—Esther Pohl Lovejoy, M.D.

Opportunities for Women in Medicine

FELLOWSHIPS

Two Ciba research fellowships are available to qualified applicants in the division of obstetrics and gynecology, University of Tennessee College of Medicine at Memphis, Tennessee.

The fellowships are a part of a four year residency leading toward a Master of Science degree in obstetrics and gynecology. The first year of this program is the fellowship year during which successful applicants will work in basic research. After this they are expected to proceed into the clinical residency. The fellowships begin July 1, and carry a stipend of $150 per month, in addition to living quarters, food, and uniforms.

Applications may be made to the Chief of the Division of Obstetrics and Gynecology, University of Tennessee College of Medicine, 894 Madison Avenue.

* * *

The National Foundation for Infantile Paralysis announces that a limited number of one year fellowships in the field of health education are available to health educators now employed in state departments of education or state departments of health. The purpose of this program is to give an opportunity for further training to those concerned with health education at the state level who intend to return to positions in state departments of education or of health. All candidates must be U. S. citizens (or applicants for citizenship) and must be in sound health. Other eligibility requirements include a baccalaureate degree, with substantial training in biological science and in education or other social sciences, and a minimum of two years as an educator in the field of health. The program may be undertaken at any school of public health in the United States that offers a graduate program in training in health education and that is approved by the American Public Health Association. Financial assistance will be given to accepted candidates for tuition and maintenance, depending on the individual need as determined by marital status and on the number of dependents. Application for these fellowships may be made to the National Foundation at any time during the year. However, applications to be considered in November must be received by Sept. 1; and for consideration in February 1956, by Dec. 1. Information may be obtained from National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5.

The Scripps Metabolic Clinic, La Jolla, Calif., invites applications for the Jacob Chandler Harper fellowship for research in medicine, which will stress laboratory investigations in the field of hematology. The stipend is $5,000 per year, with renewable one year tenure. Candidates are expected to have obtained the degree of Doctor of Medicine and to have had an approved internship, Opportunities for clinical work are excellent, but no clinical duties will be assigned. Applications should be sent to Dr. William F. Bethard or Dr. Arthur A. Marlow at Scripps Metabolic Clinic in La Jolla.

MEETINGS

The 1955 meeting of the American Goiter Association will be held in Oklahoma City, Oklahoma, April 28, 29, and 30, 1955. The program for the three day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland. For further information write: John C. McClintock, M.D., Secretary, American Goiter Association, 149½ Washington Ave., Albany, N.Y.

PHYSICIANS WANTED

The Atomic Bomb Casualty Commission of the National Academy of Sciences, which is conducting a long-term medical follow-up study of bomb survivors for late or delayed effects of radiation, is seeking an internist and a pathologist to serve as department heads at the Nagasaki installation in Japan. By July it is anticipated that replacements may be needed for two internists, one or two pediatricians, two head nurses, a radiologist, and supervisors for x-ray and clinical laboratories. The commission maintains modern clinics in both Hiroshima and Nagasaki. Medical personnel, recruited for two year terms of service, participate in the over-all routine research program and are encouraged to undertake individual problems as well, the scope of the research opportunity being largely limited by the ingenuity and research drive of the individual investigator. The commission pays for the transportation of staff members, their families, household goods, and car to and from Japan; and provides houses with basic furniture, rugs, dishes, kitchen utensils, electric stoves, and refrigerators at nominal rentals. Elementary and high schools of the local U. S. Army post are open to children of ABCC families. Salaries are about the same as for comparable positions in the United States. The cost

of living, however, is somewhat lower in Japan, and income taxes are refundable after 18 months in Japan. Information may be obtained from Frank H. Connell, Ph.D., Executive Director, Committee on Atomic Casualties, Division of Medical Sciences, National Academy of Sciences-National Research Council, 2101 Constitution Ave., Washington, D.C.

* * *

Owing to the shortage of medical officers, the Secretary of the Navy has authorized employment of civilian physicians at the industrial activities of the Navy and Marine Corps. According to the *Pennsylvania Medical Journal,* it is estimated that a total of 10 civilian physicians may be employed at the Philadelphia Naval Shipyard on the basis of a 40 hour week. Graduates of approved medical schools who have had 12 month's internship in an approved hospital and possess a license to practice in Pennsylvania or New Jersey may be considered for appointment. Applicants must be physically qualified to perform all duties assigned by the senior medical officer of the Naval Dispensary. Successful applicants may be appointed promptly and employed a month or two after security clearance. Interested civilian physicians should contact Capt. C. C. Shaw (MC), U.S.N., at the Naval Dispensary, Philadelphia Naval Shipyard (telephone HO 5-1000, extension 2290), during working hours. Personal interviews are required.

PUBLIC HEALTH SERVICE

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held on June 7, 8, and 9, 1955. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates.

Appointments will be made in the grades of Assistant Surgeon (equivalent to Navy rank of Lt., j.g.) and Senior Assistant Surgeon (equivalent to Lieutenant).

Gross pay is identical to that of officers of equivalent rank in the Army and Navy. Entrance pay for an Assistant Surgeon with dependents is $6,017 per annum; for Senior Assistant Surgeon with dependents, $6,918.

Application forms may be obtained by writing to the Chief, Division of Personnel, Public Health Service, Department of Health, Education, and Welfare, Washington 25, D.C., or from field stations of the Public Health Service. Transcripts covering all undergraduate and graduate education should accompany application forms. Completed application forms must be received in the Division of Personnel no later than May 6, 1955.

NEWS OF WOMEN IN MEDICINE

DISTRICT OF COLUMBIA. At the first fall meeting of the D. C. Chapter of the American Federation of Clinical Research, DR. ALICE N. BESSMAN and others presented "Uptake of Ammonia by the Brain in Hepatic Coma."

Recently the educational committee of the Washington Psychoanalytic Institute elected DR. EDITH WEIGERT director of the Institute. The Washington Psychoanalytic Institute is the teaching unit of the Washington Psychoanalytic Society.

DR. JEANNE C. BATEMAN has been appointed a consultant in medical oncology at St. Elizabeth's Hospital, Washington.

DR. ELEANOR SHORT has been promoted from staff psychiatrist to assistant director of the alcoholic rehabilitation division of the District Health Department. Dr. Short received her medical training at the Pennsylvania State University and Temple University School of Medicine. As staff psychiatrist at St. Elizabeth's Hospital, she completed her psychiatric residency training. In January 1950, she was appointed staff psychiatrist for the newly established alcoholic rehabilitation program.

NEW YORK. On February 2, DR. MARCELLE BERNARD spoke on "The Catholic Doctor Looks at Christian Marriage." The talk, given at Saint Philip Neri Auditorium, was part of the Pre-Cana Conferences. On February 14, Dr. Bernard delivered a radio address via Station WBNX. The topic was Pneumonia. This talk was sponsored by the Bronx Tuberculosis and Health Committee and the Bronx County Medical Society.

DR. HELEN RANNEY of New York participated in the fourth annual symposium on blood at the Wayne University College of Medicine, Detroit, Michigan. Her subject was "Some Genetic Aspects of Hemoglobin."

DR. REJANE M. HARVEY was a panel member at a session on cor pulmonale: physiopathology, diagnosis, and treatment. The panel session was sponsored by the New York Heart Association.

The section on medicine, New York Academy of Medicine, presented a symposium on Diabetes. DR. PRISCILLA WHITE, Boston, gave a preliminary report on "Attempts to Alter the Trend of Diabetes in Young Persons."

WISCONSIN. DR. JOSEPHINE PALLIN has been elected vice-president of the Fond du Lac County Medical Society.

DR. ALICE D. WATTS, of Milwaukee, was elected secretary-treasurer of the John Warton Harris Obstetrical Society at its annual meeting at Wisconsin General Hospital, Madison.

American Medical Women's Association

MID-YEAR BOARD MEETING, 1954*

The opening session of the Mid-Year Board Meeting of the American Medical Women's Association was called to order by the President, Dr. Camille Mermod, at the Dinkler-Plaza Hotel in Atlanta, Georgia, on November 12, 1954, at 9:40 a.m.

The Invocation was given by Dr. Catharine Macfarlane.

Dr. Elizabeth R. Fischer, who served as chairman of the Credentials Committee, reported a quorum to be present.

The roll was called by Dr. Carye-Belle Henle, Recording Secretary. There were eight officers, three immediate past Presidents, one Regional Director, ten committee chairmen, and the Executive Secretary present, making a total of 23.

Dr. Katharine Wright was appointed Parliamentarian.

It was moved by Dr. Elizabeth Waugh and seconded by Dr. Judith Ahlem that the reading of the minutes be omitted. The motion was carried.

Dr. Henle moved the acceptance of the minutes of the Executive Committee Meeting of June 1954. Dr. Mabel Gardner seconded and the minutes were approved as read.

The minutes of the first Board meeting in June 1954, were approved, as published in the JOURNAL, September 1954.

Several communications were read. These included letters from Dr. Nancy Catania, Dr. Esther Lovejoy, Dr. Helen Johnston, and Dr. Rebecca Rhoads, who regretted being unable to attend the meeting.

Dr. Waugh, chairman of the Publications Committee, announced the winner of the $100 prize offered for the best paper written by a student, intern or resident. This was awarded to Dr. Ruth Allen Christensen, graduate of University of Nebraska, for "The Psyche and the Skin: Their Interrelationships."

Dr. Elizabeth Kittredge announced the Medical Women of the Year, as chosen by each Branch. A picture of each was displayed and an account of her achievements read and a citation presented. The physicians thus honored were: Dr. Augusta Webster, Branch Two, Chicago; Dr. Ellen Potter, Branch Four, New Jersey; Dr. Esther Lovejoy, Branch Five, Oregon; Dr. Delia Lynch, Branch Six, Omaha; Dr. Emma Moss, Branch Eight, New Orleans; Dr. Myrtle Adams, Branch Eleven, S.W. Ohio; Dr. Pauline Rossell, Branch Twelve, Columbus, Ohio; Dr. Anita Figueredo, Branch Thirteen, San Diego; Dr. Connie Guion, Branch Fourteen, City of New York; Dr. Anna Young Beard, Branch Fifteen, Cleveland, Ohio; Dr. Mary Greene, Branch Eighteen, New York State; Dr. Elizabeth Mason-Hohl, Branch Twenty-Three, Los Angeles; Dr. Esther Greisheimer, Branch Twenty-Five, Philadelphia; Dr. Della Drips, Branch Twenty-Six, Minnesota; Dr. Harriet Gillette, Branch Twenty-Nine, Atlanta; Dr. Iva Youman, Branch Thirty-Three, Florida; Dr. Eva Dodge, Branch Thirty-Four, Arkansas; and Dr. Marion Ropes, Branch Thirty-Nine, Boston.

REPORT OF OFFICERS

President

This report, given at the Mid-Year Board Meeting of the American Medical Women's Association, is a brief resume of the activities of the Association for the past five months. For all the committees but one, the bulk of the year's work is ahead of them.

I wish, first of all, to thank those of you who have accepted committee appointments or who have volunteered for them. Your response was nothing short of phenomenal: only about 10 percent of the members did not acknowledge the requests; another 10 percent could not serve because of previous commitments, ill health or plans to be out of the country. The work which has been accomplished and the plans prepared for the rest of the year show that those of you who have consented to serve are doing it zealously.

At the Annual Meeting, in San Francisco, this June, we inaugurated the first of the yearly programs for the Association as a whole; the study of the peaceful uses of atomic energy. The suggestion has been well received by the Branches, several of which are planning programs concerning this subject. Announcements concerning lists of available speakers and films are being published every month in the JOURNAL and further information is obtainable by writing to our national office.

In line with this interest of the American Medical Women's Association, a resolution urging the participation of the other members of the Medical Women's International Association in this program was introduced at the MWIA meeting in Gardone, Italy, on September 15, 1954. This resolution was unanimously passed, and you will find the full text of it in the September JOURNAL.

At its June meeting, this Board approved honoring outstanding medical women in this country. The committee on "Medical Women of the Year" was headed by our First Vice-President, Dr. Elizabeth Kittredge. Again the interest and response of the whole membership was most gratifying: 17 Branches have taken the opportunity to honor an outstanding medical woman. The president of one of the Branches said to me: "the difficulty is not to find an outstanding woman physician, but to choose one, only." We hope that the project will be continued, and that, in this way, many more outstanding women will be honored by this Association.

We took as the underlying theme of this year's work activities an increased attention to the world around us. The work of the committees on Medical Education for Women, Opportunities for Medical Women, Publicity and Public Relations, Organization and Membership, and Junior Branches are all planning expanded programs along this line.

Thanks to more funds being available, resulting from the Muhl bequest, the Scholarship Loan Committee has been able to grant more loans. The question as to whether we should make some outright grants as well as loans could be discussed in the course of the next few months.

The International Committee is being re-vitalized under the chairmanship of Dr. Ada Chree Reid. It is of the utmost urgency that all of us participate actively in this part of the program. We must reach all foreign medical students and doctors and show them that we are truly interested in them and their problems. They, in turn, will become our ambassadors of good will to their native countries.

Our helpful friendliness must not stop with foreign students, but should include all interns and women medical students. They must all feel that we as an Association and as individuals stand ready to be of service to them. In this connection, the work of the committees on Organization and Membership, Publicity and Public Relations, and Junior Branches are leading the way.

The advisory committees on Legislation and Public Health will show us other ways in which our help can be made more effective.

Other committees are channelling their energies into specialized fields: The Woman's Medical College Committee, the Publications Committee, the Library Committee, and the Service Committee. All of them are to be congratulated on their excellent work.

The efficiency of our national office has been increased by the addition of a secretary to help Mrs. Majally, our Executive Secretary, and allow her to devote more of her time to other work. In taking this step, much of the purely clerical work (such as sending out form letters) which heretofore swamped willing committee workers will be avoided. This should make committee membership less of a burden to all of you.

I feel that our year's work is well started, and hope that the same enthusiasm will continue to be with us the rest of the year.

—CAMILLE MERMOD, M.D.

Recording Secretary

Dr. Carye-Belle Henle was unable to be present at the initial Meeting in June 1954, but the national office kept things up to date for her.

Corresponding Secretary

The Corresponding Secretary worked with Dr. Kittredge on the Medical Women of the Year project.

Treasurer's Report

The Treasurer's report was presented and accepted as read. We are staying within our budget and our financial condition is excellent.

The audit from July 1, 1953, to December 31, 1953, has been done by Haskins and Sells of New York. Our audit for January 1, 1954, to December 31, 1954, will be done January 1, 1955, by this same firm.

The number of members and the report of the various funds were given in detail at the Meeting.

—ELIZABETH R. FISCHER, M.D.

* * *

Report of the Executive Secretary

The four and one-half months since the Annual Meeting have been administratively successful. Much has been accomplished in the area of inter-organization relations, in public relations with other organizations, and in Association operation.

There has been a consistent effort to collect outstanding dues. It is gratifying to report that many members who have not been in good standing for four and five years have been reinstated. There has been a consistent gain in new members and excellent prospects for a greatly increased Junior membership.

*This is a summary of the proceedings and of the reports of officers, Regional Directors, Committee chairmen, and Branches. The verbatim minutes, and unabridged reports are on file with the records of the American Medical Women's Association in the New York office.

The 1955 dues payable notices were mailed on November 3 to all members except those in Branches where Association dues are collected locally. As of November 10, dues were received from approximately 15 percent of the 1954 members.

Notices will be mailed to all Associate members who graduated prior to 1951 with the hope that a high percentage will become Active members this year. Notices will be sent also to those who are delinquent for 1954. Someone has said that every reclaimed delinquent member, or reinstated member, is the equivalent of two new members.

It was a pleasant experience this past week to have a New York doctor phone the office and ask how she might become a member. On the opposite side of the picture is the letter received from a doctor in a southern state who wrote, "I would very much like to be a member of the American Medical Women's Association. However, since I am not a member of a State or County medical society, I am trying to find an endorser who is a member of the AMWA." This woman is connected with a prominent University and had written for reprints of several articles which appeared in the JOURNAL. Tear sheets had been sent to her with the comment that she was not a member and that we would be glad to welcome her to membership.

Working with Dr. Sargent, chairman of the Medical Education Committee, we mailed, in September, notices of the 1955 Cash Awards and the Honorable Mention Citations to the Dean of each of the Medical Schools, along with a September JOURNAL in which the pictures and biographies of the 1954 Award winners appeared, and a request for lists of the women medical students. As these names are received, the lists are sent to Dr. Kahler. In this way we are attempting to co-ordinate the work of the Education Committee and the Director of Junior Membership.

New membership cards and receipts were designed and printed. The Constitution and By-Laws have been printed as authorized by action of the 1954 Annual Meeting. A copy of the Constitution and By-Laws is mailed with each membership card and receipt for 1955 dues.

The final checking has been completed for the mimeographing of the membership directory, which will contain the names of the Active members in good standing, the Life members, Emeritus, Associate, Junior, and Memorial members. We hope to send out the directories this month.

A full-time secretary, Mrs. Olga T. Mielke, was employed as of August 1, and I assure you that without her capable assistance it would be impossible to carry the work load.

Correspondence grows increasingly heavy, more time is devoted to committee work, assistance is given to Branches as requested, especially where it has been possible to aid in arranging programs on the 1954 theme, Constructive Uses of Atomic Energy. Every Branch is invited to use this service provided through the national executive office.

It is interesting to note that public relations have been established with many firms wishing to serve the Association: for instance twelve hotels have extended invitations by letter or personal calls to the Association to use their facilities for meetings. One steamship line and four railroads have extended the same courtesy; the Convention Bureau and the Mayor of Galveston, Texas, have extended an invitation to bring an AMWA meeting to their city.

At the request of Dr. Mermod, I went to Atlantic City in August and completed the physical arrangements for the 1955 Annual Meeting at the Hotel Dennis. We have been advised that if AMWA members wish to remain for the AMA sessions, it will be necessary to make reservations through the Atlantic City Convention and Housing Bureau in order to retain the same room after June 5. Full details to appear in the January JOURNAL.

A personal invitation was received from the AMA to attend the AMA Public Relations meeting in Florida next month.

A number of interesting and challenging letters have been received in the office. I would like to present for your thinking a few excerpts from these letters:

On October 11, I received a letter from Thomas R. Forbes, assistant dean of the Yale University School of Medicine in which he says, "I should be very grateful if you could provide information or suggested references to the literature which would shed a little light on the perennial question as to whether male or female graduates are more likely to continue in medical careers. This is a frequently discussed problem, and I have found almost no pertinent and factual information relating to it."

On September 2, a lengthy letter was received from Ellen H. Mueser, placement director at Wheaton College in Norton, Massachusetts; she said in part, "I am in need of some vocational information in relation to women in the field of medicine (M.D.'s only).—I have examined the resources of our college library but do not find sufficiently current breakdowns of the desired information.

"I particularly need to know: The number of women M.D.'s in the continental U. S. today.—I notice in the *AMA Journal* that there was an upswing in the number of doctors in 1953. Did this trend hold true for women M.D.'s as well? . . . Can you direct me to literature of recent (underscored) years which considers why medicine is not as popular a profession amongst women as it was earlier in the century? . . . Is there any recognized ratio figure of women as contrasted to men students in medical schools? Is there any over-all figure of the totals who apply for admission (both men and women) to medical schools as against those accepted? . . . Would you be willing to suggest what you recommend to be the best current clip and article material or book references for good vocational information on medicine as a profession for women (not the related medical fields, but the M.D.'s). We seem most lacking in material in this field and would like to build up our resources."

This letter was answered and we again heard from Miss Mueser on September 27, when she said, "Your reply has enabled me to complete with assurance of much greater accuracy and helpful additions an article for the college newspaper and (the information) will be available to students in our counseling office for further helpfulness to them . . . I am sure a number of our students will be very much interested in the material."

On November 5, the following letter was received from Charles M. Sanders, First Lt., USAF (MSC) Chief, Medical Staffing and Education Branch Office of the Surgeon, Headquarters Fifteenth Air Force, March Air Force Base, California: "The following question has been asked. What is woman's part in the world today? . . . The American Hospital Association, of which I am a member, has referred your Association to me. I am most desirous of rendering an accurate and scientific answer to the above question, therefore, I am writing to you for assistance. Specifically, it would be appreciated if the following questions were answered: 1) How many women physicians are there in the USA today as compared with 50 years ago? 2) Education and Opportunities. Are there any medical colleges that restrict admittance to only males? 3) Graphs and charts, or other material available relative to the subject."

This particular correspondence is cited as evidence for need of informative literature on these subjects.

As part of the work of the ensuing months I would recommend that a committee or committees be appointed to prepare concise, factual pamphlets on "Medicine, a Career for Women" and "Medical Women Use Their Training."

Many other varied and interesting letters, replies to which can greatly further interest in the work of the Association, are received almost daily in the office, such as the letter received from Mrs. Alice K. Leopold, on August 20, when she reported on the recent ILO meeting and asked,

"We would like to have a meeting to talk about the international work of the Women's Bureau and of correlated government groups. Do you feel that the members of your organization would like to have such a meeting? We should be interested in receiving your reaction to such an idea, and would also appreciate any suggestions you may have for a discussion of this kind . . . If there are other matters which you would like to discuss, or if we can be of help to your organization in any way, it is our hope that you will at all times write freely to us."

In reply it was suggested by Dr. Mermod that women physicians would be interested in discussions related to pregnancy, sick leave, health education, and holidays with pay, and that AMWA members would be willing to serve as discussion leaders at such a conference.

It is with full sincerity that I say that under the inspired leadership of Dr. Mermod, the Association has moved forward in all aspects of its work: that, with continued leadership such as the Association has been privileged to enjoy during the two years of my connection with the organization, I am sure greater advances will continue to be evident.

—LILLIAN T. MAJALLY

REPORTS OF STANDING COMMITTEES

Elections

The Elections Committee is ready to serve as soon as a slate is presented by the Nominating Committee. Ballots will be sent out to the membership and counted when returned.

—CLEMENTINE FRANKOWSKI, M.D.

Historical

The Historical Committee, which numbers among its members Dr. Esther Pohl Lovejoy, author of several books on Women in Medicine, and Dr. Elizabeth Bass, the compiler of the historic "These Were the First," is still seeking to further the writing of valuable historical information whether in the form of research or biographic books, and to acquire and preserve, in the library of the Woman's Medical College of Pennsylvania until the Association has its own library, all scientific reports written by women doctors who are members of the Association. The article by Dr. Antoinette Le Marquis, a former member of the Historical Committee, is of particular value in bringing to younger members of the AMWA the importance of medical writing.

The acquisition by the Association of the tape recorder has made possible the preservation of records of meetings and speeches as well as putting at the disposal of the membership a comparatively simple method of preserving the present for future reference.

Doubtless a hundred years from now, if not sooner, the Association will own a colored television machine, which will permit the members of a future century to participate, as interested spectators and auditors, in the crucial doings and thoughts of our young atomic age.

The committee has some progress to report: Dr. Ellen C. Potter is assembling material for her autobiography, which will include not only epoch-making times, but also her own epoch-making life and participation in events, and in their creation, which carried the practice of medicine out of its private limitations into state and world-wide scope.

Dr. Catharine Macfarlane, honored with many awards, has written the beginning of her autobiography.

Miss Mary Sabin, sister of Dr. Florence Sabin, has been written to, suggesting to her the writing of a biography of her famous medical sister.

Several requests have come to the committee this year for bibliographic material for research papers to be read before clubs. Dr. Jeanne M. Stark is engaged in writing a paper on women doctors who also became teachers. This will be a valuable research historical document of both practical and inspirational value. These requests have been referred to Miss Ida J. Draeger, librarian of the Woman's Medical College of Pennsylvania, custodian of the medical material of the Association, and an honorary member of the Historical Committee. Without her valuable knowledge and eager assistance, the valuable medical material already accumulated would be almost useless. The possession of a library of its own is most urgently needed by this Association.

Among the members there will always be those who like to put pen to paper, whose thoughts and ideas become clarified and gain in importance through being written down. All these writers need the encouragement and stimulus of ultimate publication. The planning of a place for publication, through affiliation with a well-known publishing house and, if necessary, the guaranteeing of a subsidy from the Association, or the use of a private press, will soon become a matter of vital importance and a prime necessity.

At the present time, publishing houses with their high production costs hesitate to publish many valuable books, especially if their appeal is limited primarily to one profession. And though many medical books have a human interest appeal wider than the roster of the profession, yet they are often books of limited circulation, no matter how important and valuable their contents may be to doctors.

The universities have solved this problem by the creation of university publishing houses. Whether the time has come, or is about to come, for this Association to take the matter into consideration, is for the Association to say. The Historical Committee, however, begs leave to bring the question to the attention of the Association.

—GULIELMA FELL ALSOP, M.D.

International

The functions of this committee have not previously been formulated, and we submit for your consideration the following as a tentative outline of the objectives of this committee.

1. To assist the National Corresponding Secretary, who is the liaison between the AMWA and the MWIA, and to support and publicize the program of the MWIA.

2. To co-operate with other committees of AMWA, such as Opportunities and Scholarships, in obtaining assistance for foreign medical women.

3. To promote international hospitality; we feel this hospitality should be extended on the local level and that it would be the responsibility of the Branch representative to obtain the names of all foreign interns and residents in the local hospitals. In regions where there is no Branch, we suggest that any woman physician should consider herself responsible for seeing that the foreign medical women are invited to homes and to meetings. Names of visiting medical women are being obtained from various sources such as United Nations and WHO, the American Association of University Women, our State Department, the Institute of International Education, National Council of Women, Boards of Foreign Missions, and various other sources. The names thus obtained will be sent to the Branch or to an individual in the locality where the foreign doctor is working. To co-operate with other agencies in this field, we would like to suggest that the American Medical Women's Association become an associate member organization of the International Hospitality Committee of the National Council of Women of the United States. There are 27 such organizations at present representing the more important of the women's clubs and we feel that the AMWA should be associated with this group. Details of the Association are appended to this report.

4. To foster good international relations with governmental and non-governmental organizations; to that end we feel that the AMWA at this meeting should re-affirm its confidence in the United Nations. Since the World Health Organization is the agency of the United Nations engaged in the field of international health, we would suggest that the AMWA become a sponsoring organization of the National Citizens Committee For The World Health Organization. The contribution to the National Citizens Committee would be $100 annually. In further support of this committee, we would like the AMWA to authorize the solicitation of membership in the National Citizens Committee among the members of the AMWA. Another organization working in the field of international health is the World Medical Association. This is an association composed of national groups of physicians, the expenses for which are contributed mostly by the United States Committee of the World Medical Association. We would like the AMWA to assist in the support of this United States Committee by authorizing the solicitation of memberships among the women doctors of the United States.

We feel that our support of these two organizations, the National Citizens Committee For The World Health Organization and the United States Committee of World Medical Association, will be a demonstration of our conviction that through international co-operation we women physicians are contributing our share to international understanding and world peace.

—ADA CHREE REID, M.D.

Dr. Sargent and Dr. Fischer were designated by Dr. Mermod to get in touch with Dr. Reid regarding opportunities for women as interns, residents, or paid physicians in hospitals.

Legislative

The Committee on Legislation has not held a meeting.

The members have been contacted by mail, and asked to write an article for the JOURNAL on some phase of recent legislation in which they were interested.

—RUTH ELLIS LESH, M.D.

Library

The Library Committee defers its report of the plans for the inauguration of the effort to secure funds until the Annual Meeting in June.

—MABEL E. GARDNER, M.D.

Medical Education for Women

Announcements were mailed to all the deans of the medical schools telling them that the American Medical Women's Association is again offering awards to the women graduating in first place from each medical school and citations to the ones placing in the upper ten of their classes. These were dated September 15, 1954.

So far we have excellent results in correspondence from the deans. Many suggestions have been offered. First place possibilities are from the University of Colorado Medical Center, Tulane of Louisiana, and George Washington University of the District of Columbia. Acknowledgements and "advise later" are coming in. Several have stated that they have no women in the senior class this year.

—EVA R. SARGENT, M.D.

Medical Service—American Women's Hospitals

The work of the American Women's Hospitals for the last six months is a continuation of that reported at the Annual Meeting in June.

Interesting reports, however, have been received from several different countries, especially Korea and the Philippines. Some of this material has already been sent to the JOURNAL for publication. On November 5, 1954, the following letter, signed by Dr. Fe del Mundo, past president of the Philippine Medical Women's Association (who has been named as the outstanding woman doctor of the Philippines for this year), was received, together with interesting photographs regarding the work:

"Your most encouraging letter of congratulations made me very happy. I will read this letter to the Board during the next meeting. I am sure that our Board will all be happy to know that our work is recognized by you. We realize that we should try our best to be worthy of the help which you are extending to us. Your help is very important not only for what we can accomplish with it, but also for the spiritual effects on us."

We have also received reports from India, Haiti, and Greece with a photograph of Dr. Nelie Noble, past President of the AMWA, visiting the AWH Polyclinic at Nikaia, Greece.

—ESTHER P. LOVEJOY, M.D.

An additional letter from Dr. Lovejoy was read by Dr. Mermod.

Opportunities for Medical Women

On September 3, 1954, all members of the committee received letters from Dr. Trent, welcoming them to membership in the committee and advising them that they should look for any opportunities for medical women in their territories, and forward this information to the chairman for editing and processing for publication in the JOURNAL. In addition, all committee members receive a postal card reminder monthly asking them for any information regarding local opportunities.

The JOURNAL has been supplied monthly with processed information ready for printing, of fellowships, internships, staff appointments, scholarships, and so forth, available to medical women.

In addition, letters from women physicians seeking specific types of positions in their locales have been processed by the chairman, and any opportunities available to them in their lines of interest have been forwarded to them. The greatest need seems to be to find part-time work in research or other fields for married women with children who do not wish to lose contact with medicine during their childbearing and homemaking years. We definitely need help in finding such opportunities for these women as soon as they occur.

The committee has been organized and functioning for only two months. Much has been accomplished during this brief span of time and it is hoped that this will continue in the future.

—SOPHIE TRENT, M.D.

Organization and Membership

The principal work accomplished by the Organization and Membership Committee so far this year has been the attempt to accumulate data and material from which to work in initiating the organization of new Branches, both Junior and Senior. The work so far has been conducted by mail. Letters have been sent out by the chairman as follows:

June 10, 1954. Letters to Dr. Elizabeth Kahler and Dr. June Dvorak concerning Junior Branch at the University of Wisconsin.

September 18, 1954. Letter to Dr. Mary Jennings, with step-by-step procedure for forming a branch.

September 18, 1954. Letter to Dr. Kahler, enclosing material received from Dr. Ruth E. Lesh, including list of medical schools.

September 18, 1954. Letter to Dr. Elizabeth Paterson about new Branch in Austin, Texas.

September 18, 1954. Letter to Dr. Lesh acknowledging material received.

September 20, 1954. Letter to Mrs. Majally re Branch report forms, admission blanks, and model by-laws, names of members of Membership and Organization Committee, monthly list of new members to be sent to appropriate Regional Directors.

November 28, 1954. Letter to Dr. Mermod concerning Board Meeting.

September 28, 1954. Letter to Regional Directors and other members of Organization and Membership Committee.

November 9, 1954. Reports mailed out of work of Organization and Membership Committee.

The only meeting of the committee was the one for a breakfast, November 13, at the Dinkler-Plaza Hotel. At this meeting the Regional Directors and members of the Organization and Membership Committee brought in the material requested in the above letters, and began to formulate a procedure to be followed by any interested in organizing new branches, and planned model by-laws to be used as a guide for the new branches.

—EDITH PETRIE BROWN, M.D.

Publications

The committee held a meeting on October 17, 1954, in Philadelphia. There were four members present, and Dr. Mermod and Dr. Geib. The main item of business was consideration of a budget for the coming year. The budget was based on last year's audit, allowing for a slight increase in production costs. It was decided to use this as a working budget and that final adoption of the budget should be postponed each year until the yearly audit has been made.

The finances of the JOURNAL are in good condition. We have been able to pay our bills currently and have no outstanding debts. We have also been able to maintain an adequate bank balance.

Dr. Elizabeth McGrew of Chicago has consented to be a new member of the Publications Committee. The resignation of Dr. Beulah Cushman has been accepted with regret.

A copy of the September financial statement of the treasurer is attached as part of this report.

—ELIZABETH S. WAUGH, M.D.

Public Relations and Publicity

This will, of necessity, be a very brief report since to date the Committee on Public Relations and Publicity has not had an opportunity to confer and organize a program. It was late in October when the list of physicians willing to serve on this committee was received. An outline of a tentative plan for operation has been made and submitted to Dr. Mermod for suggestions. It is hoped that some, or all of the members of the committee will be at the meeting in Atlanta so that further plans may be discussed. All the members of the committee have been contacted.

At his request, a copy of the September issue of the JOURNAL OF AMERICAN MEDICAL WOMEN'S ASSOCIATION was sent to Mr. Brown of the American Medical Association, Department of Public Relations. A letter from him states that he had noted the article on the award winners of 1954, and he has requested that a story on this article be incorporated in the news release which is being sent out to the daily newspapers throughout the country. Copies of this story have been promised.

—MARY W. TYLER, M.D.

Scholarships

The Scholarships Loan Fund granted loans in September to five women. Three were additional loans to applicants from the previous year and two were new applications. There was also a loan granted in November to a new applicant. These loans were in the amount of $500. Because of the increased cost of medical education, books, living expenses, and so forth, we have applications from three more girls for $1,500 and so the problem should be settled if we are going to limit the amount loaned in each year to each applicant.

We were very fortunate in June to receive a gift of $30,000. This raises the question of how we should dispense it in the best way: 1) Lend it in unlimited amounts to applicants each year? 2) Give a limited amount? or 3) Invest part and give out the rest, or invest all of it and use only the interest?

We also received an increase to the principal of the Glasgow Fund.

At present the Scholarships Loan Fund has a fair amount of money to lend.

—ANN GRAY TAYLOR, M.D.

Woman's Medical College of Pennsylvania

The one hundred and fifth session of the Woman's Medical College opened on September 10, 1954. The guest speaker was Dr. Edgar Mayer, clinical professor of medicine at the New York University Graduate School of Medicine. His topic was "If I Were Beginning the Study of Medicine Today."

Fifty-one new students from 24 states and 4 foreign countries brought the total enrollment up to 182. A number of well-qualified applicants were refused admission for lack of space.

It is not necessary to emphasize to this group the important role played by women physicians in general practice, preventive medicine, industrial medicine, research, and the specialties.

In this connection, however, the committee wishes to call your attention to the report of the Council on Medical Education published in the September 15 issue of the *Journal of the American Medical Association*. This report shows that there has been a steady decrease in the number of women graduated from the medical schools of this country and Canada during the last five years, from 12.1 percent in 1949 to 5.5 percent in 1953.

Competition for admission to the medical schools is keen. The enrollment of women in the co-educational schools is nearer 5 percent than 10 percent. As a former President of the American Medical Women's Association has said: "If the number of women physicians in this country is to be increased, the Woman's Medical College of Pennsylvania must graduate them."

To meet this challenge, the College needs more space, laboratory space, clinic space, library space, and so on. At a recent meeting, the Board of Corporators approved "in principle" a plan presented by the Chicago firm of Schmidt, Garden and Erikson. This firm is at the top of the list of architects and engineers specializing in hospital and medical school work.

The main feature of the plan is a new wing, five stories high, which would provide increased laboratory space, a larger and well-equipped library, and more adequate quarters for the administrative offices. The estimated cost of the new wing, plus remodelling of the present college building to permit necessary expansion of the hospital, is $1,416,000. This investment will make it possible to meet more adequately the needs of the present student body, as well as make it possible to increase the total enrollment by 20 percent.

Included in the estimate is the sum of $175,000 for the new library. What more fitting memorial could be found to honor and perpetuate the name of the Founder of the American Medical Women's Association—our beloved leader, Dr. Bertha Van Hoosen.

—CATHARINE MACFARLANE, M.D.

Reference Committee B

Only one officer's report was received. It is unwise to review officers' reports. It is better that the officers give their own.

Perhaps the work of this committee is unnecessary and it is suggested that a constitutional amendment be made deleting all but Reference Committee A.

—HELENA RATTERMAN, M.D.

Junior Membership

Summer is not a very good time for Junior Branch work. Report forms were sent out in October, and so far only two replies have been received. There are seven active Junior Branches; four have completed their applications and by-laws folders. One copy with seal attached has been returned to each of these Branches. One copy is kept in the New York office as part of the permanent records, and one permanently at the school. When the number in any school is too small for a Branch, the by-laws are a tangible reminder and incentive to reactivate the Branch when enough are enrolled.

Actually, in addition to the seven Branches, there are large numbers of members at Woman's Medical College who are not organized as a branch. In addition also to the members in Branches, there are 30 Junior members in 11 other schools, members-at-large in more than one quarter of all the medical schools. A letter has been received from Harvard wanting information on organizing a branch. Owing to lack of contact over the past few years, Branches that started before 1952—the University of California, University of Pittsburgh, University of Utah, and Vanderbilt—have dissolved. Our report forms and by-laws folders will be of great help to prevent dissolution in the future.

Mrs. Majally has been a tremendous help. She has obtained names of students. The JOURNAL has been helpful also. The November JOURNAL went to the students in all the schools. It carried the list of Junior Branch officers, a page on how to organize Junior Branches, and become Branch members, and Junior Branch news. We hope to follow this up with a letter and invitation to membership, or organization of a Junior Branch, in each school, if the students wish. The ground work has been pretty well laid. With the help of the JOURNAL and the members we have bright prospects for the future.

—ELIZABETH S. KAHLER, M.D.

SPECIAL COMMITTEES

Alice Stone Woolley Memorial Fund

The gross amount collected to date for the Alice Stone Woolley Memorial Fund is nearly six thousand dollars.

It is with deep sorrow that we report the death of Dr. Virginia Beyer, late a member of this committee.

The committee is working on the choice of a lecturer for the June meeting; the decision will be made in the spring.

—THERESA SCANLAN, M.D.

REPORTS OF REGIONAL DIRECTORS

Northeast Central

To date, only an incomplete report is ready, but more activity is in progress. Two state directors have reported:

1. Dr. Elaine M. Thomas of Milwaukee reports for Branch Ten as follows: medical women in Wisconsin have a nominal affiliation with Branch Ten, which is the Milwaukee Medical

Women's Society. Some, in nearby communities, pay local Branch dues to us; the majority do not. An annual social meeting, including all state medical women who are attending the State Medical Society convention, is usually held during the convention. All pay Association dues independently, if they are members; we do not collect those.

2. Dr. Clementine Frankowski of Indiana reports that she was unable to attend the dinner for the women physicians given by the Indiana State Medical Society in Indianapolis, and that her delegate, Dr. Alice H. Davis, reported slight response among the women physicians approached about the AMWA. It was concluded by the State Director that the best way to develop a branch in Indiana would be through starting a junior branch in the Indiana University Medical School. She has written to a woman doctor who might be interested in helping with this plan; and if she receives a favorable response, this person will contact Dr. Elizabeth S. Kahler, Director of Junior Branches.

3. For Ohio, State Director Dr. Marjorie Grad and assistant Dr. Jean Nitchals have been appointed as of November 5. Dr. Grad, who is the president of Branch Eleven, is one of the younger doctors in that area. Neither she nor Dr. Nitchals has worked long in the organization, but they are enthusiastic and will be of great help to this committee.

4. A letter was written to Dr. Mary Margaret Frazer of Detroit, requesting suggestions for state director in Michigan; no answer to this has yet been received.

5. The previous state director in Illinois is not available, and a letter has been written to Dr. Esther E. Hodel, requesting that she take this position. No answer has been received from her as yet.

—KATHARINE W. WRIGHT, M.D.

Southwest Central

A suggested outline of procedure for the formation of a branch is submitted. It is quite necessary to be sure that at least five or six women are interested before beginning.

1. Get a list, if possible, of all women graduates of approved medical schools in the area. This is sometimes more difficult than it sounds. County medical membership lists may be used. However, there are often a number of women who are in salaried positions and do not belong to the county medical, who would like to join the AMWA.

2. Send out an invitation to all of them to meet to discuss organization of a group and follow this up with telephone calls.

3. Elect a temporary chairman and secretary, have by-laws, and make a list of those present.

4. Present the advantages of belonging to a national organization. Scholarships, the JOURNAL, and the opportunities for women nationally, are the best selling points.

5. Decide just what the local main objects will be, such as help to students, women residents, and interns.

6. Present a suggested constitution and by-laws. The most discussed points will be meetings and dues.

7. Decide on time for next meeting for final organization and admission of charter members, adoption of constitution and by-laws.

8. Send out minutes of meeting including list of those attending first meeting and copies of proposed constitution and by-laws to original list (whether they attended or not) with notice of meeting for permanent organization.

9. Try to get newspaper coverage.

10. At next meeting adopt constitution and by-laws. Set final date for charter members, elect permanent officers.

—MARY A. JENNINGS, M.D.

REPORTS FROM THE BRANCHES

Branch Two, Chicago, Illinois, started what appears to be a successful year with several board meetings.

Two regular meetings were held; one on October 7, was a joint meeting with the Women's Bar Association, women dentists, and women administrators in the field of education. The women administrators are a new addition to our group. A communication was received from this group asking that they be included in the future.

"The Coroner: Doctor or Layman," was discussed from the medical point of view by Dr. Edwin F. Hirsch, pathologist at St. Luke's Hospital; and Mr. Edwin Roemer from the legal standpoint. Mr. Roemer is past president of the Chicago Bar Association. The much publicized Montgomery Ward-Thorne case came into discussion. The various deficiencies of the present system were brought out.

The second meeting was held November 10. At this meeting, interns and residents of Chicago area were our guests. There were 34 interns and residents present. The program was a panel discussion on Careers in Medicine for Women. Dr. Eleanor Humphrey, pathologist at University of Chicago, was moderator, and the following members participated: Dr. Catherine L. Dobson, obstetrics and gynecology; Dr. Helen D. Heinen, pediatrics; Dr. Beulah C. Bosselman, psychiatry; Dr. Bertha L. Isaacs, internal medicine; Dr. Adele Gecht, surgery; and Dr. Victoria B. Vacha, general practice.

The program for the remainder of the year includes: Christmas party, December 12; "New Diagnostic and Therapeutic Methods in Congenital Heart Disease," by Dr. Bessie Lendrum, January 12; panel discussion on Cancer Detection, with Dr. Luella E. Nadelhoffer, moderator, and a panel consisting of Dr. Evangeline E. Stenhouse, Dr. Eloise Parsons, Dr. Marie Ortmayer, and Dr. Augusta N. Webster, February 1; Women and Children's Hospital meeting, a panel discussion on the cost of medical care, with Dr. Elizabeth R. Fischer, moderator, and participants Dr. Margaret Stanton, Dr. Natalie Stephens, Dr. Katherine K. True, and Miss Katherine Ragan, April 13; May meeting, May 11; and annual meeting. The objectives of the Branch are to increase membership and to stimulate better fellowship.

—CLEMENTINE E. FRANKOWSKI, M.D.

Branch Four, New Jersey, is planning a meeting on the peaceful uses of atomic energy. They also plan to put into effect the preceptorship program.

—M. EUGENIA GEIB, M.D.

Branch Ten, Wisconsin, is a promising section. An attempt is being made to organize in Madison.

—ELAINE M. THOMAS, M.D.

Branch Eleven, Southwestern Ohio, has held one meeting since summer, on September 19, 1954. It was an informal meeting at the home of Dr. Marjorie Grad.

This meeting was attended by 15 members and 15 guests, many of whom were of foreign birth, serving in the hospitals of greater Cincinnati.

Reports of medical meetings of the AMA and AMWA were submitted.

—RACHEL BRAUNSTEIN, M.D.

Branch Fifteen, Cleveland, Ohio, held one meeting, at which Dr. Anna Young Beard, a non-member, was selected Medical Woman of the Year.

—EDITH PETRIE BROWN, M.D.

Branch Eighteen, New York State, is responsible for editing the February JOURNAL. After the deadline for this issue, any scientific papers which have not been published and any interesting facts about women in medicine in your community or the history of your organization should be sent to Dr. Adelaide Romaine, who has been appointed the reporter for the Branch for future issues of the JOURNAL.

A new committee, the committe for opportunities for medical women, has been formed. Dr. Ethyle Little has been appointed chairman. The duties of this group are to obtain a list of part-time positions open to medical women.

Another new committee, the international committee, is headed by Dr. Anna Manitoff, whose duties will be to obtain the names of foreign interns in our hospitals and to promote the sharing of our meetings and hospitality of our homes with the intern staffs both foreign and domestic.

The delegates for the AMWA Mid-Year Meeting November 12 to 15, 1954, are Dr. Myrtle Wilcox and Dr. Elizabeth Vuornos.

The annual meeting of the New York State Women's Medical Society will be held in Buffalo on May 8, 1955. Dr. Annabel Miller has prepared a very interesting meeting both from the scientific and the social standpoint.

—ELIZABETH P. OLMSTEAD, M.D.

Branch Twenty (Blackwell), Detroit, Michigan, held an interesting meeting with women lawyers.

—MARY MARGARET FRAZER, M.D.

Branch Twenty-Five, Philadelphia, Pennsylvania, holds three meetings a year. Each year an award is made to the woman student who makes the greatest progress.

—ELIZABETH S. WAUGH, M.D.

UNFINISHED BUSINESS

Report on Muhl Legacy

Dr. Ahlem reported that the legacy was accepted at the Annual Meeting in 1953. Through expert legal advice, the ruling that the bequest must be spent in California has been put aside. The total is about $25,000. We are part owners in Indiana real estate, which we have been advised to dispose of and on which we have been advised to secure liability insurance in the interim. We also are part owners of stock in Magnolia Petroleum Oil Company of Dallas, Texas, and Big Springs Casdon Petroleum. Transfers are being completed so that the royalties will be mailed to the fiduciary legatees.

The Executive Committee agreed that Dr. Ahlem continue as representative of the Association in this matter and that she be empowered to sell the real estate and wind up the legal aspects of the Muhl Estate. Dr. Ratterman moved ratification of the action of the Executive Committee. Carried. Dr. Mermod said the above authority would be sent to Dr. Ahlem in written form.

Survey on the Study of Women in Medicine

Dr. Stenhouse stated that preliminary report was given at the last Annual Meeting, and a completed report will be presented at the next Annual Meeting, June 1955.

The Executive Committee had discussed the possibility of hiring legal counsel on a retainer fee basis, but did not consider it wise because of the varying conditions of legal practice in the different states. It was requested that the Board sanction this action. This was moved, seconded, and passed.

NEW BUSINESS

The theme of the 1955-1956 program was announced at this meeting in order to give the Branches time for the preparation of programs. The Executive Committee approved the topic, "Industrial Medicine." Dr. Macfarlane moved that the action be ratified. Carried.

1. Submitted by the Finance Committee: **Be it resolved** that all available funds be placed in Savings Banks protected by Federal Insurance; these accounts not to exceed $9,000 in the initial deposit so as to be always insured. Life funds becoming available in 1955 are to be placed in a similar account.

It was moved by Dr. Evangeline Stenhouse to add the following amendment by the Resolutions Committee: **Be it resolved** that all available funds be placed in savings accounts in National Banks only, and so forth.

Original motion withdrawn by Dr. Elizabeth Brackett as chairman of Finance Committee, who then moved the amended resolution. Carried.

2. Dr. Stenhouse moved that all interest from the Life Membership Fund shall be transferred annually to the General Fund. Carried.

3. Dr. Stenhouse further moved that use of any of the capital of the Life Membership Fund shall require action of the Board of Directors. Carried.

4. Dr. Stenhouse moved that the Committee on Constitution and By-Laws be asked to draw up an amendment to Article VII of the By-Laws incorporating the above actions. Carried.

5. Submitted by Finance Committee: **Be it resolved** that the Mead and Donahue Funds be combined into one account.

It was moved by Dr. Stenhouse that the following amendment be added: that the Mead and Donahue Funds be combined into one account to be known as the Mead and Donahue Fund. Carried.

6. It was moved by Dr. Stenhouse that the Board of Directors approve the employment of a clerk-typist, that her time be divided between the Association and the Publications Committee, the allocation of her time to be arranged by the Executive Secretary in consultation with the chairman of the Publications Committee; the employee to be directly responsible to the Executive Secretary. Carried.

7. Submitted by Dr. Elizabeth Waugh: The Publications Committee recommends that the AMWA pay to the Publications Committee Fund a specified amount per member including Active, Associate, and Junior members, per year. Subsidiary motion: that the matter be deferred for Board action until it can be brought back with better wording in order to clarify what needs to be done.

Dr. Brown submitted the following amendment: The Publications Committee recommends that the AMWA pay to the Publications Committee Fund a specified amount per member for all members as a subscription to the JOURNAL. Carried.

8. Dr. Stenhouse submitted: that a contract be entered into with the Executive Secretary, stipulating salary, vacation time, and sick leave. Carried.

9. Moved by Dr. Kate Zerfoss:

a. That a vote of thanks be extended to the Dinkler-Plaza Hotel for their courteous care, fine accommodations, and excellent food during the Mid-Year Board Meeting. Carried.

b. That a standing vote of thanks be extended to Dr. Elisabeth Martin and her committee of Branch Twenty-Nine for their great courtesy and thoughtfulness in arranging hotel accommodations and meals, press and television coverage, transportation, flowers, and favors; and especially to Dr. Amey Chappell for the hospitality in her home. Carried.

10. Presented by Dr. Catharine Macfarlane: **Resolved** that the Editor and Publications Committee be requested to publish in the JOURNAL at a date as early as possible a digest of all previous existing articles covering the percentage of women physicians who continue in the practice of medicine after graduation. This was moved by Dr. Zerfoss. Carried.

11. Presented by Dr. Mermod: Resolved that a committee or committees be appointed to prepare factual, concise pamphlets on the two following subjects, "Medicine, A Career for Women" and "Women Use Their Medical Training." Moved by Dr. Zerfoss. Amended: that pamphlets be prepared on, and so forth. Carried.

12. Submitted by Dr. Elizabeth Kittredge, Dr. Edith Brown, and Dr. Elizabeth Fischer: **Resolved** a) that the term of all officers except the Treasurer and Assistant Treasurer be extended from one to two years; b) that this change be effected by electing President, President-Elect, Second Vice-President, and Corresponding Secretary for the first second year term starting in June 1956, and the First Vice-President and Recording Secretary starting in June 1957; and c) that the necessary Constitution and By-Laws amendments be made.

Dr. Stenhouse moved that this matter be referred to the Executive Committee. Original motion defeated.

13. Resolution by the Finance Committee: We further move that the Publications Committee contribute annually to the Association an amount equal to that received for the JOURNAL subscription. Carried.

14. Resolution presented by Reference Committee B to amend the By-Laws, Dr. Helena Ratterman: Delete all of Section 20, Article V, setting up Reference Committees B, C, and D. Section 20 will then read: "There shall be a reference committee appointed by the President at least two months prior to the time of meeting during which they are to serve. When a motion, resolution, or report is referred by any committee, the Reference Committee shall review and discuss the matter referred, and hear debate thereon by any interested member of the Association, and shall submit its recommendations in writing to the Board of Directors, or to members at the Annual Meeting." This was moved by Dr. Zerfoss.

A subsidiary motion was made by Dr. Brown: that the matter of Reference Committees be referred to the Constitution and By-Laws Committee so that all matters pertaining thereto may be put into proper constitutional amendments to clarify the recommendation of the Reference Committee. Carried.

15. **Resolved** that the Board of Directors recommend that an amendment be added to the By-Laws, incorporating a standing committee on Constitution and By-Laws, with rotating membership. This was moved by Dr. Brown. Carried.

16. The following resolutions were presented by Dr. Ada Chree Reid:

a. That the American Medical Women's Association reaffirm its support of the United Nations and its agency, the World Health Organization, by becoming a subscribing member organization of the National Citizen's Committee For The World Health Organization, with a subscription of $100 annually; and **be it further resolved** that the AMWA further indicate its approval by permitting its mailing lists to be used in a membership drive by the Citizens' Committee. Dr. Brown moved that the matter be referred to the Executive Committee for study and report at a later date. Carried.

b. That the AMWA become a member of the International Hospitality Committee of the National Council of Women of the United States, co-operating with the 27 organizations of women in the United States now so affiliated. Dr. Fischer moved that this matter be referred to the Executive Committee for further study and report. Carried.

c. That the AMWA indicate its approval of the World Medical Association, and allow its mailing lists to be used in a membership drive by the United States Committee of the WMA. Defeated.

The dates of the Annual Meeting were announced as being June 2 through June 5, 1955. Dr. Marting said that she had been asked by Branch Eleven to extend an invitation to the Association to hold the Mid-Year Meeting in Cincinnati, in 1955. Dr. Ahlem moved that we accept with thanks. Carried.

Dr. Brackett suggested that we formulate a rule regarding our organization becoming a member of another organization. Dr. Stenhouse stated that it was not in the Constitution but that it was in the minutes and that it had always been regarded as an unwritten law that we did not. Dr. Ratterman moved that the meeting be adjourned. Carried. The meeting was followed by the fellowship luncheon.

NEW YORK INFIRMARY

Announcement is made of Alumnae Day at the New York Infirmary on June 2, 1955. There will be clinical sessions, a luncheon, and dinner. All women doctors are cordially invited to attend. Please contact Dr. E. Catherine Cline, New York Infirmary, 321 East 15th Street, New York, New York.

Book Notices

EDITOR'S NOTE: These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.

PRACTICAL FLUID THERAPY IN PEDIATRICS. By Fontaine S. Hill, M.D., Assistant Professor of Pediatrics, University of Tennessee College of Medicine, Memphis; Staff Member of the John Gaston Children's Hospital and the LeBonheur Children's Hospital. Pp. 275, 20 figures. Price $6.00 W. B. Saunders Company, Philadelphia, 1954.

This book presents a practical approach to problems of fluid therapy in infants and children based on fundamental pathophysiologic principles. It attempts to bring the busy physician up to date on changing terminology and the newer concepts in the field of fluid and electrolyte balance, but emphasis is on the clinical application of the facts. It is divided into three sections: 1) basic considerations; 2) diagnosis and treatment; and 3) technical procedures.

The book has valuable tables of information and helpful concise data which many readers will want to add to their armamentarium. It will serve as an excellent guide for pediatricians and general practitioners alike in the management of such varied conditions as diarrhea, pyloric stenosis and other abdominal surgical conditions, diabetes, burns, and salicylate intoxication. Other noteworthy sections deal with the role of potassium, water intoxication, lower nephron nephrosis and respiratory acidemia and alkalemia. Finally, this is one of the few books which contains a detailed description of the various techniques of obtaining blood specimens by venipuncture, and of administering fluids parenterally.

—Sol Browdy, M.D.

MAXILLOFACIAL ANATOMY. By Harry H. Shapiro, D.M.D., Assistant Professor of Anatomy, College of Physicians and Surgeons, Columbia University; Visiting Lecturer in Applied Anatomy, Tufts College; Consultant, U.S. Army Medical Service Graduate School, Walter Reed Hospital, Washington, D.C.; Maxillofacial Surgeon in Plastic Surgery, Manhattan Eye, Ear and Throat Hospital, New York City. Pp. 392, with 312 illustrations, 46 in color. Price $12.00. J. B. Lippincott Company, Philadelphia, 1954.

Practitioners of medicine and dentistry and particularly maxillofacial surgeons will find much to interest them in this anatomic study. The author describes the embryonic development of the face, jaws, and associated regions of the head and neck with excellent illustrations and brief but complete discussions.

The anatomic review chapters on skeletal framework of this region offer many practical points of great interest to clinicians, such as the roentgen anatomy of this area and the value of encephalograms as diagnostic aids. Regions of the nose, lips, and cheeks are particularly well covered including the anatomic considerations responsible for alterations, aberrations or gross deformities. The author draws liberally from photographs and sketches of many clinicians to illustrate his text, but the figures are well chosen and establish relative facts quickly and concisely.

The neuroanatomic considerations of the cranial nerves and pain pathways are particularly valuable, for here the author offers scientific evidence of little understood phenomena in dealing with abnormalities or diseases of this region. In general this book reflects the author's skill in correlating a detailed study of the head and neck structures while relating this knowledge usefully to clinical practice. The book is concise, accurate, and most informative to any student of medicine, but will be best appreciated by maxillofacial surgeons, for whom it was designed specifically.

—Alma D. Morani, M.D.

THE ENCYCLOPEDIA OF CHILD CARE AND GUIDANCE. Edited by Sidonie Matsner Gruenberg. Pp. 1,016. Price $7.50. Doubleday and Company, Inc., Garden City, N.Y. 1954.

The editors of this Encyclopedia have attempted to combine specific recommendations in child care with what they call "that broader understanding of fundamental attitudes which will help each reader to develop a personal guide for successful living with children." Although the book is a bulky one, the impression is that too often the "fundamental attitudes" are emphasized and re-emphasized at the expense of necessary detail.

There are two sections in the book, arranged in what appears to be a reverse order. Part II, titled "Basic Aspects of Child Development," consists of 30 short articles by as many different authors. All of them are interesting and useful; those on "The School Years," "Art Experiences for Children," and "Music for Children" are particularly good and contain material not often found in other books.

Part I has 568 pages of short comments arranged in alphabetic order, from "Abilities" to "Youth Organizations." Almost every one of these is cross-referenced to other sections. Some of the references are rather unexpected, such as "Peek-A-Boo, see Anxiety" or "Standing, see Walking."

A more serious criticism is that this section is unduly long. Some of the topics are of questionable value: under what circumstances would one want to look up "Modern Mother"? Others are repetitious; there is no good reason for separate sections on "Average Child," "Individual Differences," and "Normal Child." Still others are unnecessarily subdivided, as "Musical Instruments," "Musical Appreciation," "Music Lessons," and "Music Practice."

Too many of the related sections repeat basic material; it would have been better to have concentrated the general discussions under a few topics, and given more concrete detail in the subdivisions. There is too much reiteration of the undoubtedly basic needs for love and acceptance and so forth, and too few helpful suggestions for the solving of specific problems.

At the end of Part I is a good reading list, and an invaluable directory of national agencies concerned with child care.

Anyone can find individual points of difference with the various writers; that is inevitable with any book on child care, and does not necessarily detract from its usefulness. This Encyclopedia should be in reference libraries. For the individual reader, it does not offer enough new or unusual material to make it worth the extra cost.

—M. Eugenia Geib, M.D.

CLINICAL ALLERGY. By French K. Hansel, M.D., M.S., Director, Hansel Foundation for Education and Research in Allergy; Chief of Allergy Service, DePaul Hospital, St. Louis. Pp. 1,000. Price $17.50. The C. V. Mosby Company, St. Louis, 1953.

According to the author, this book is designed to serve as a complete text on the subject of allergy. The organization of material and treatment of the varied manifestations of allergic disease indicate that the book is provided for the edification of the general practitioner and the pediatrist. This is eminently fair and practical, since the general practitioner or pediatrist is usually the first to see the patient suffering from allergic disease, and the establishment of the diagnosis is of the utmost importance. On the other hand, much of the discussion is somewhat vague and inconclusive if viewed from the standpoint of the general practitioner, but definite enough from that of the specialist in allergy: for example, the discussion of the indications for tonsillectomy in an allergic patient. The emphasis for the individualization of treatment is to be agreed with, heartily. The indications or standards of this same individualization of treatment are, however, not clearly outlined.

The chapter on "Entomogenous Allergy," a name coined to indicate allergy to insects and their products, is excellent and most helpful. The chapters on the anatomy, physiology, histology, pathology, and bacteriology of the nose and paranasal sinuses are complete, exact, and informative. The discussions of the many other aspects of allergic disease are, for the most part, equally good, although occasionally one feels that the information is a little vague.

There is a glossary for the benefit of those not well versed in the terminology and nomenclature of the subject. One cannot help noting the ever-lengthening list of new terms, many of which seem obscure and unnecessary; for example-hyperergy, normergy, procutin, and anticutin. Knowing the as yet unresolved dilemma of the use and misuse of the term "atopy," there might be less ambiguity if fewer supposedly specific words were coined.

Several non-specific therapeutic measures are discussed, such as the use of Staphylococcus Toxoid, Histamine, and the "Ionization" of the nasal mucosa. To many, measures such as these were heroic experiments, long unused and forgotten. One must hope the general practitioner does not get the impression that they are recommended. To be sure, Dr. Hansel says repeatedly that the most meticulous attention to details must be given in the establishment of the diagnosis of allergic disease, and that specific immunizing treatment must be given for a sufficiently long period before resorting to non-specific measures if the immunizing treatment is not sucessful. However, it might have been better to have omitted some of these discarded treatments from discussion.

Dr. Hansel's volume is exhaustive and impartial, full of valuable information with great practical worth.

—Leoni N. Claman, M.D.

Books Received

The following books have been received for review, and are recommended to our readers.

STUDYING AND LEARNING. By Max Meenes, Professor and Head, Department of Psychology, Howard University. A Doubleday Paper in Psychology, Number 9. Pp. 68. Price $0.95. Doubleday and Company, Garden City, New York, 1954.

ART AND PLAY THERAPY. By Emory I. Gondor, Research Assistant and Art and Play Therapist, New York Medical College, Flower and Fifth Avenue Hospitals. A Doubleday Paper in Psychology, Number 10. Pp. 61. Price $0.85. Doubleday and Company, Garden City, New York, 1954.

THE ANATOMY OF PERSONALITY. By Donald K. Adams, Ph.D., Professor of Psychology, Duke University. A Doubleday Paper in Psychology, Number 11. Pp. 44. Price $0.85. Doubleday and Company, Garden City, New York, 1954.

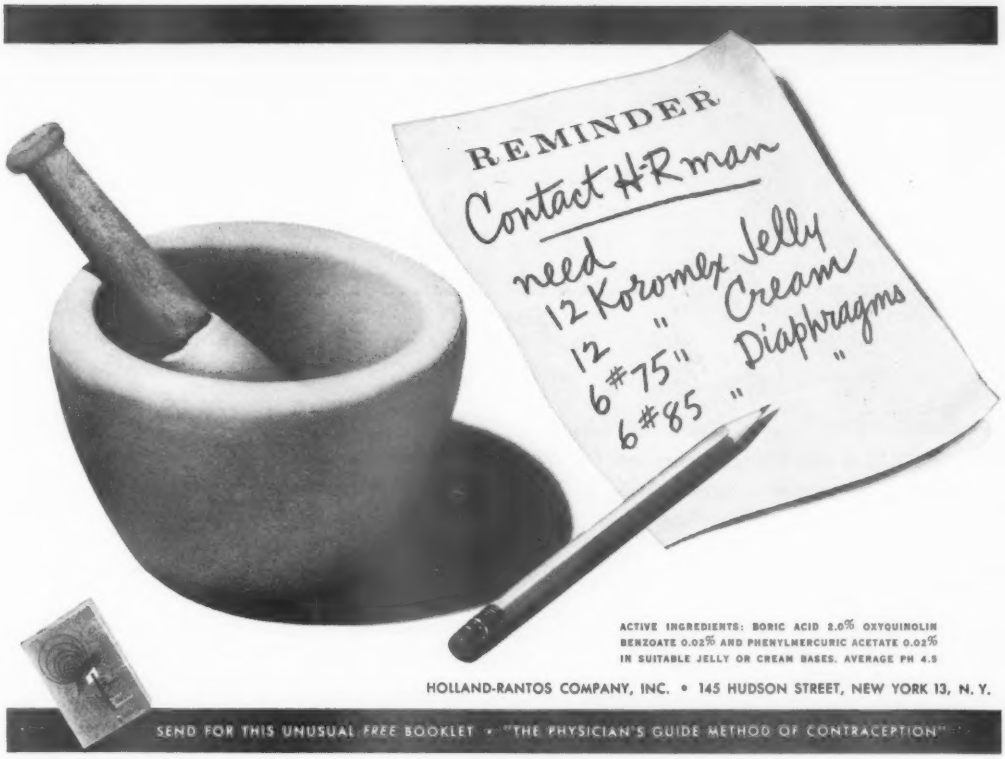
ON THE NATURE OF PSYCHOTHERAPY: BASIC DEFINITIONS AND ASSUMPTIONS FOR STUDENTS OF PSYCHOLOGY AND MEDICINE. By Arnold Bernstein, Instructor in Psychology, Queens College. A Doubleday Paper in Psychology, Number 12. Pp. 36. Price $0.85. Doubleday and Company, Garden City, New York, 1954.

THE OPTOMETRIST'S HANDBOOK OF EYE DISEASES. By Joseph I. Pascal, B.S., M.A., O.D., M.D., Director of Eye Department, Stuyvesant Polyclinic; Associate Ophthamologist, New York Polyclinic Medical School and Hospital; and Harold G. Noyes, A.B., A.M., M.D., Associate in Optometry, Columbia University; Clinical Assistant in Ophthalmology, Manhattan Eye, Ear and Throat Hospital. Pp. 294, with 155 illustrations and 3 color plates. Price $9.50. The C. V. Mosby Company, St. Louis, 1954.

THE WORK OF WHO 1953: ANNUAL REPORT OF THE DIRECTOR-GENERAL TO THE WORLD HEALTH ASSEMBLY AND TO THE UNITED NATIONS. Official Records of the World Health Organization, Number 51. Pp. 190. Price $1.50. Columbia University Press, New York, 1954.

METHODOLOGY OF PLANNING AN INTEGRATED HEALTH PROGRAMME FOR RURAL AREAS: SECOND REPORT OF THE EXPERT COMMITTEE ON PUBLIC-HEALTH ADMINISTRATION. A World Health Organization Technical Report Series Number 83. Pp. 46. Price $0.25. Columbia University Press, New York, 1954.

DONOVANOSIS (GRANULOMA INGUINALE, GRANULOMA VENEREUM). By R. V. Rajam, M.S., F.R.C.P., Director, Venereal Disease Department, Government General Hospital, Madras; Professor of Venereal Diseases, Madras Medical College; and P. N. Rangiah, M.D., Associate Professor of Venereal Diseases, Madras Medical College. Pp. 72, figures 38. A World Health Organization Monograph Series Number 24. Price $1.50. Columbia University Press, New York, 1954.



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EDITORIAL FORECAST

May 1955

Dr. Elizabeth B. Brown is the Guest Editor for the special Branch Twenty-Five, Philadelphia, issue of the JOURNAL, to appear in May. A variety of articles will be presented, and material about medical women in Philadelphia.

"Pediatric Allergy," by Elizabeth B. Brown, M.D.

"The Proteins," by Esther M. Greisheimer, Ph.D., M.D. Dr. Greisheimer was chosen Medical Woman of the Year by Branch Twenty-Five, and her biography is the "Album of Women in Medicine" for this number.

"Immediate Care and Resuscitation of the Newborn Infant," by Elizabeth S. Waugh, M.D. This paper was presented as part of a course in pediatrics for the general practitioner, sponsored by the Commission on Graduate Education, Medical Society of the State of Pennsylvania, in Wilkes-Barre, October 27, 1954.

"Acute Intermittent Porphyria," is a case report by Gertrude LaBotz Crum, M.D.

"A Mid-Century Look at Woman's Opportunity for Service to Mankind," by Mrs. Dorothy D. Houghton. This speech was presented before the Woman's Medical College of Pennsylvania on June 9, 1954.

CONSTITUTION OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

Article III, Section 1a. **Active Members** "shall be members of a Branch, if any local Branch exists; if not, they may be Members-at-large."

Article III, Section 6. **Associate Members** "shall be: (1) Medical women in the first year of practice; (2) women interns, residents-in-training, and fellows. Associate members shall not pay dues and shall have all privileges of memberships, except voting, holding office, and membership in the Medical Women's International Association."

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Names included: All members with dues paid on December 31, 1954
Addresses: As on file in the executive office
Specialties: As on file or listed in the AMA Directory—1950

We have been advised—

"AMWA delegates requiring sleeping rooms during the American Medical Association convention can reserve such accommodations *by writing directly to the Reservations Department of THE DENNIS specifying their departure date as not before June 9.* Upon receipt of this reservation, a confirmation will be sent requesting a good faith deposit which will be applied against the room occupancy charge on the nights of Tuesday, June 7, and Wednesday, June 8."

—JOHN E. LEISHMAN, *Director of Sales*
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The Dennis urges that AMWA reservations for June 2-5 be made at once. Demands for AMA reservations make this imperative.

For AMWA reservations use the blank on opposite page.

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Double and Single with connecting bath (3 persons) $18——

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TV—Four Programs For "The March of Medicine"

The first of a spring series of television programs was produced by the sponsors of "The March of Medicine" telecasts on March 29th over a coast-to-coast network. In the course of a documentary medical program entitled "Ten Years After Hiroshima," the audience was taken on a detailed tour of the reconstructed Japanese coastal city where 100,000 people died in the explosion which helped to bring an end to World War II. Reports on the latest research in American medical centers on the treatment of radiation sickness were also seen and heard. This was the fourteenth in the continuing series of programs sponsored and produced by Smith, Kline & French Laboratories in cooperation with the American Medical Association. It was presented at the Los Angeles meeting of the American Academy of General Practice, and included a special report to the meeting by Dr. Stafford L. Warren*, Dean of the U.C.L.A. School of Medicine, in which he described the role of the American physician in the difficult new problems of civilian defense in the atomic era. Also featured was a visit to the research laboratories in Boston and Chicago for a report on significant work currently in progress on radiation problems. The sequence included the activities of Dr. Sidney Farber and his staff on blood studies. Dr. Farber is director of the Children's Cancer Research Foundation and professor of pathology at Harvard University. The program also covered the work of Dr. Leon Jacobson, director of the Argonne Cancer Research Hospital in Chicago, and the radiation studies of a group of scientists at Argonne National Laboratory at Lemont, Illinois.

To gather material for this first on-the-scene account of atomic radiation after-effects and to report on the work of the U.S. Atomic Bomb Casualty Commission, the "March of Medicine" production team traveled halfway around the world. The Commission is composed of a staff of more than 500 American and Japanese doctors, technicians, and assistants working under the direction of the American pathologist, Dr. Robert Holmes.

Three telecasts remain in the series designed for the spring. The second will be held at the time of the meeting of the American College of Physicians on Tuesday, April 26, in Philadelphia; the third will feature the annual meeting of the American Psychiatric Association in Atlantic City; the fourth and final show of the series will emanate for the American Medical Association's gathering on June 7, also in Atlantic City.

Color Film on Lung Segments

"Bronchopulmonary Segments: Anatomy and Bronchoscopy" is a half hour color movie which provides the audience with an opportunity to explore the recesses of man's breathing apparatus. It was shown first at Temple University School of Medicine. Co-authors of the film are Dr. Chevalier L. Jackson, internationally known specialist, Dr. John F. Huber, and Dr. Charles M. Norris, all of the Temple faculty. The film depicts a relatively new concept of human anatomy in describing the lung segments. Knowledge of these divisions of the lungs enables the physician to diagnose and treat tuberculosis, lung cancer and other conditions with greater precision. The film follows Dr. Jackson as he performs a bronchoscopy, showing the audience exactly what is seen by the bronchoscopist as he probes deep inside the chest.

More than a hundred medical organizations are scheduled to see the film in this country within the next few weeks. It has been loaned to the State Department by Pfizer and will be shown to physicians at the Far Eastern Medical Congress in Tokyo this month.

The script was written by Dr. Leo L. Leveridge, Director of Pfizer Laboratories' Medical Film Department, who planned the picture with the authors and collaborated with Campus Film Productions in making the film.

*Dr. Warren led the first American medical team into Hiroshima at the end of the war.

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IT HAS BEEN REPORTED THAT—

"Successful homografts are possible under some conditions," but the evidence for success in this field has been extremely rare, according to Dr. C. Parker Meek of Aiken, South Carolina. On the affirmative side, he cites the example of a skin homograft in the case of a nine year old boy with third degree burns, covering approximately 32 percent of his body surface. Two weeks after admission to the hospital, debridement of the burned area was performed, chiefly of the thigh and legs. Twelve days later four 3 by 9 inch split-thickness skin grafts taken from the thighs of the boy's father, were transplanted to the patient's left leg and thigh. At the same time, and in four subsequent operations, smaller grafts from the patient's own skin were transplanted to the right thigh. Furacin® (Eaton) dressings were applied to the grafted areas. After 11 months, the homograft is still surviving and showing no indication of sloughing. This evidence, together with a report from France of a successful homograft from mother to daughter, led Dr. Meek to the conclusion quoted above. (*American Journal of Surgery,* 88: 504 Sept. '54.)

The itchy rash of poison ivy can be prevented from developing by the use of a certain drug combination found to be effective up to eight hours after exposure, according to Dr. G. A. Cronk and Dr. D. E. Naumann, of the Department of Health and Preventive Medicine, Syracuse University. The medication, known as Bristamin with zirconium, combines a form of zirconium oxide and the antihistamine phenyltoloxamine dihydrogen citrate.

Before the clinical tests, the subjects, who had previously been proved sensitive to poison ivy extract, had the remedy rubbed into patches of their skin both before and after application of the active extract of the plant. It was found that after three days, "A typical poison ivy dermatitis was present at the control areas," but that "no dermatitis was observed at the treated areas."

The lotion should be applied before the rash develops, for once it has done so, the drug serves only to relieve itching. In the tests, the doctors waited as long as eight hours before rubbing on the Bristamin medication and found that it was still effective in preventing the rash. It is said that the lotion did not produce any unpleasant side effects on the subjects. Repeated tests showed that the results with Bristamin were reproducible in every instance.

Since 1934 it has been known that the allergenic agent of poison ivy is an oleoresin of the type known as urushiol. It has been suggested that hydrous zirconium oxide combines with certain chemical groups of the oleoresin and inactivates them. Presumably, the antihistamine component of the medication inhibits the body's reaction to the allergic agent in the plant by countering the release of histamine in the skin tissues. (*Antibiotics and Chemotherapy,* 5: 64, 1955.)

A blood clotting test, simple, inexpensive, and easily administered has been devised by doctors at George Washington University. It may prove a great boon to victims of heart and blood diseases such as coronary thrombosis, for it makes possible anticoagulant drug treatment at home. The new test can be performed at the patient's bedside by any physician or trained technician after 20 minutes of instruction. Devised by Dr. Benjamin Manchester, assistant clinical professor of medicine, the new test determines the effectiveness of drugs, such as dicumarol and tromexan, which are used to combat blood clotting in heart and blood diseases. It has been administered more than 12,000 times by him and by Dr. Boris Rabkin, instructor in medicine.

The test requires only a drop (2/10 cu. mm.) of blood, as compared to the 4 to 5 cc. of blood which must be obtained by venipuncture for most other tests. Since clotting time tests must be performed daily on patients receiving anticoagulant treatment, the amount of blood required for a test is important. Results from the new test can be obtained in one and one-half minutes. Other tests require 20 to 30 minutes.

In performing the test, a drop of blood, removed by pricking the patient's finger, is added to an equal amount of a biochemical (rabbit brain thromboplastin), and according to the length of time required for clotting to result (14 to 18 seconds is normal), the amount of anticoagulant drug to be administered is determined. The accuracy of this test is important for effective control of treatment. An article published in the November issue of *The Journal of Circulation* and titled "The Control of Dicumarol Therapy in Myocardial Infarction by a Simple Blood Prothrombin Test," is the first report in a medical publication of results from widespread home use of the test. (Condensed from *The Courier of the George Washington University Medical Center,* Dec. '54.)

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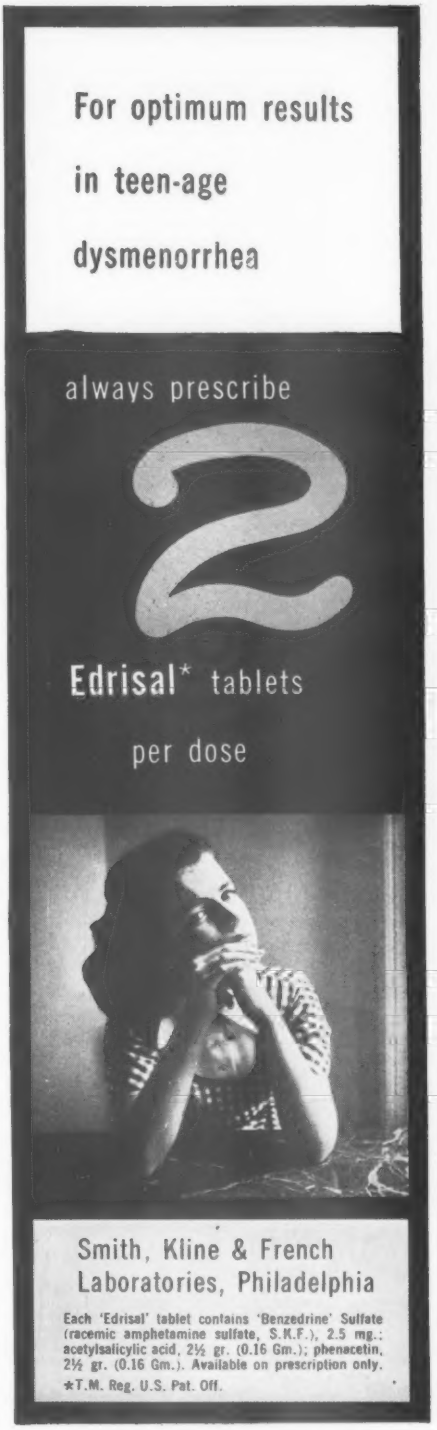
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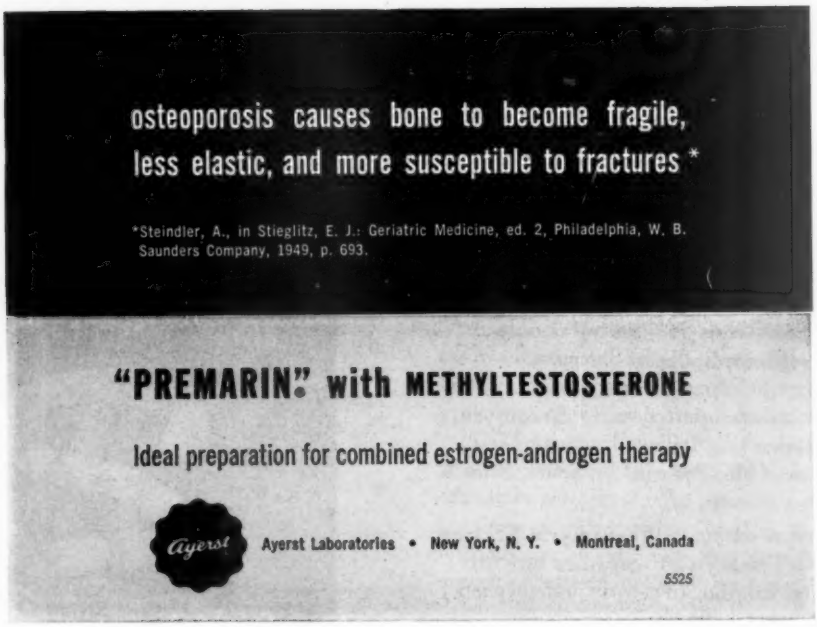
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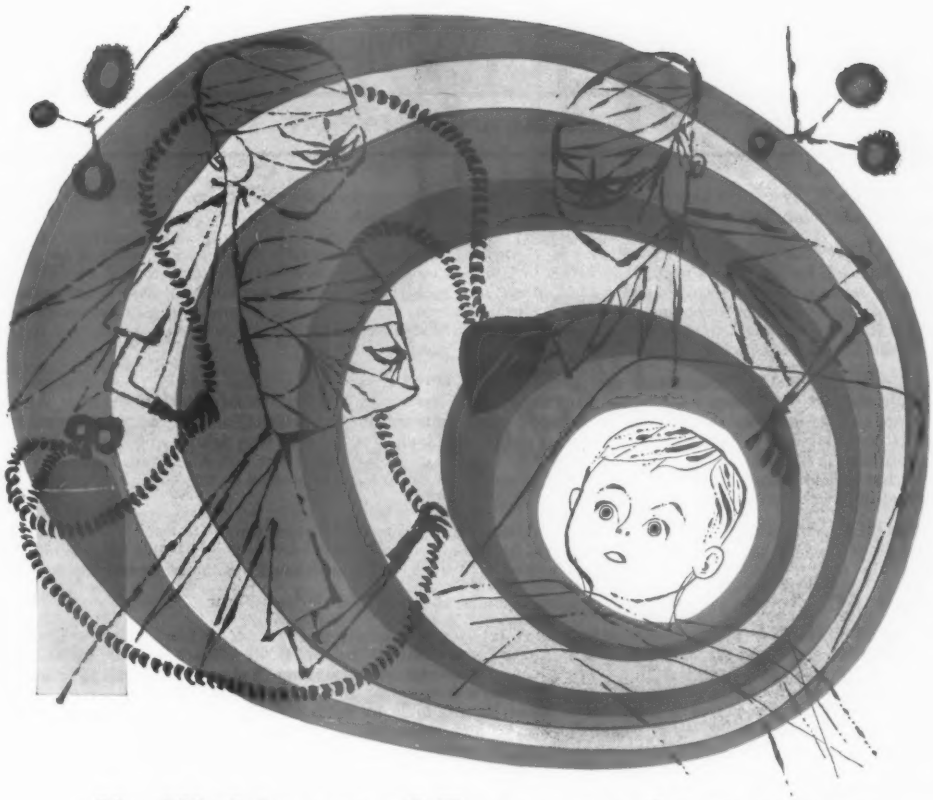

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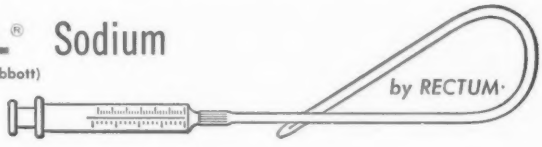

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Journal of the
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IN CONCEPTION CONTROL

"...WHEN THEIR LIVES DEPEND UPON IT"

Recently, discussing the contraceptive efficacy of the "jelly-alone" method, Jackson predicted that in time it "will find its own level of usefulness, but it should not be handed out to highly fertile parous women, particularly when their lives depend upon it, in the mistaken belief that it will protect them as fully as one of the combined methods (cap or sheath plus spermicide)."[1]

"The added protection of a diaphragm..."

"Where avoidance of pregnancy is important... the added protection of a diaphragm should be prescribed,"[2] stresses Gamble. And Greenhill,[3] Novak,[4] Reich and Nechtow,[5] and the Council on Pharmacy and Chemistry of the A.M.A.[6] agree that the diaphragm-jelly method offers the most dependable conception control, with reliability of 95% to 98%.[2,4]

Indications for the jelly-alone method

Although "diaphragms can be fitted to almost all women,"[3] some women do not use them for anatomical, physiological, economic or psychological reasons: ■ Relaxed pelvic floor[5,7] ■ Extensive cystocele[3,5,7] ■ Extensive rectocele[3,5,7] ■ Intact hymen[3] ■ Short anterior vaginal wall[7] ■ Third degree retroversion of uterus[7] ■ Acute anteflexion of the uterus[7] ■ Complete prolapse[3] ■ Personal preference ■ Crowded living conditions ■ Inability to learn technic ■ No urgent need to avoid pregnancy[8,9] ■ Unwillingness to use the diaphragm ■ Fear of impairing future fertility ■ Low parity[1,8,9]

Selective safety

For such patients the physician may prescribe RAMSES VAGINAL JELLY* alone with confidence, as demonstrated in a study by Guttmacher and associates.[8] In 325 women observed who had used the jelly-alone (RAMSES VAGINAL JELLY) method from 3 months to 3 years, the total unplanned pregnancy rate was only 16.7 per 100 patient-years of exposure. Of these pregnancies, *over 35% were due admittedly to patient's negligence or failure to use method properly. Thus the actual pregnancy rate was 10.82 per 100 patient-years of exposure.*[8]

All women in this study had one child or more. Significantly, those with more than one child had almost twice as many unplanned pregnancies as those with one child only. Guttmacher and associates conclude that the jelly-alone method *will be more effective in nonparous women and in women of low parity.* They believe that the patients' "intelligence, motivation, parity, and ready access to new supplies all affect success or failure."[8]

Prescribing for the individual

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References: 1. Jackson, M. G.: Lancet 2:346 (Aug. 15) 1953. 2. Gamble, C. J.: Ann. New York Acad. Sc. 54:840 (May 2) 1952. 3. Greenhill, J. P.: Office Gynecology, ed. 5, Chicago, The Year Book Publishers, Inc., 1948. 4. Novak, E.: Textbook of Gynecology, ed. 3, Baltimore, The Williams and Wilkins Co., 1948. 5. Reich, W. J., and Nechtow, M. J.: Practical Gynecology, Philadelphia, J. B. Lippincott Co., 1950. 6. Council on Pharmacy and Chemistry of the A.M.A.: New and Nonofficial Remedies for 1954, Philadelphia, J. B. Lippincott Co., 1954. 7. Tietze, C.; Lehfeldt, H., and Liebmann, H. G.: Am. J. Obst. & Gynec. 66:904, (Oct.) 1953. 8. Finkelstein, R.; Guttmacher, A., and Goldberg, R.: Am. J. Obst. & Gynec. 63:664 (March) 1952. 9. Barnes, J.: Lancet 2:401 (Aug. 22) 1953.

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	4-5, 28-29, 43
Ayerst Laboratories	42
Beech-Nut Packing Company	—
Bristol-Myers Company	23
The Coca-Cola Company	19
Hoffmann-La Roche, Inc.	1, (16-17)
Holland-Rantos Co., Inc.	33
Lederle Laboratories	10-11, 17, 37
Eli Lilly & Company	32
The S. E. Massengill Company	2
Mead Johnson & Company	Back Cover
Ortho Pharmaceuticals	39
Parke, Davis & Company	31
Pfizer Laboratories Div. of Chas. Pfizer & Co., Inc.	20-21
J. B. Roerig & Co.	25
Schering Corporation	14-15
Julius Schmid, Inc.	13, 45
Sharp & Dohme	35, Ins. Back Cover
Martin H. Smith Company	36
Smith, Kline and French Laboratories	9, 41
Tampax Incorporated	48
The Upjohn Company	27, 47
Winthrop-Stearns, Inc.	7

INDEX TO PRODUCTS ADVERTISED

Adrenocortical Extract
- Cortate *(Shering)* 14-15

Analgesics
- Dolophine Hydrochloride *(Lilly)* 32
- Edrisal *(Smith, Kline & French)* 41

Androgen Therapy
- Oreton *(Shering)* 14-15

Anesthetics
- Pentothal Sodium Rectal *(Abbott)* 43

Anorexigenic Agents
- Desbutal *(Abbott)* 4-5
- Dexedrine Sulfate *(Smith, Kline & French)* 9
- Obedrin *(Massengill)* 2

Antibiotics *(See also Penicillin Therapy)*
- Achromycin *(Lederle)* 10-11

—with Vitamins
- Terramycin-SF *(Pfizer)* 20-21
- Tetracyn-SF *(Pfizer)* 20-21

Anticonvulsants
- Dilantin Sodium Kapseals *(Parke, Davis)* ..31

Antidepressants
- Desbutal *(Abbott)* 4-5
- Dexedrine Sulfate *(Smith, Kline & French)* 9

Antiemetics
- Gravidox *(Lederle)* 37

Antihypertensives
- Reserpoid *(Upjohn)* 27, 47

Antinauseants
- Dexedrine Sulfate *(Smith, Kline & French)* 9

Antispasmodics
- Expasmus *(Martin H. Smith)* 36

Conception Control
- Koromex *(Holland-Rantos)* 33
- Preceptin *(Ortho)* 39
- Ramses Products *(Julius Schmid)* 45

Dietary Supplements
- Prenatal Capsules *(Lederle)* 17
- Iberol Filmtabs, *(Abbott)* 28-29
- Natalins *(Mead Johnson)* ..... Back Cover
- Obron *(Roerig)* 25

Estrogen Therapy
- Estinyl *(Shering)* 14-15
- Progynon *(Shering)* 14-15

Estrogen-Androgen Therapy
- Gynetone *(Shering)* 14-15
- Premarin with Methylestosterone *(Ayerst)* 42

Hematinics
- Iberol Filmtabs *(Abbott)* 28-29

Hormone Therapy *(See Androgen Therapy, Estrogen Therapy, Estrogen-Androgen Therapy)*

Inhalation Therapy
- Alevaire *(Winthrop-Stearns)* 7

Laxatives
- Sal Hepatica, *(Bristol-Myers)* 23

Penicillin Therapy
- Remanden *(Sharp & Dohme)* Ins. Back Cover

—with Vitamins
- Pen-SF *(Pfizer)* 20-21

Progestin Therapy
- Pranone *(Shering)* 14-15
- Proluton *(Shering)* 14-15

Protozoacides
- Vagisec *(Julius Schmid)* 13

Soft Drinks
- Coca Cola *(Coca-Cola Co.)* 19

Stimulants (Cerebral & Central Nervous System)
- Dexedrine Sulfate *(Smith, Kline & French)* 9

Tampons
- Tampax *(Tampax Incorporated)* 48

Vaginal Creams, Jellies & Ointments
- Koromex *(Holland-Rantos)* 33
- Preceptin *(Ortho)* 39
- Ramses *(Julius Schmid)* 45

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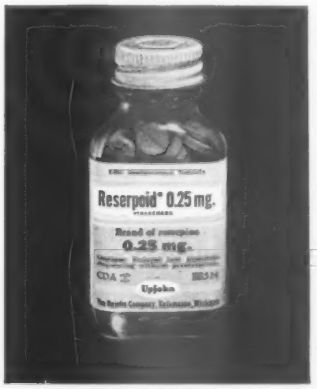

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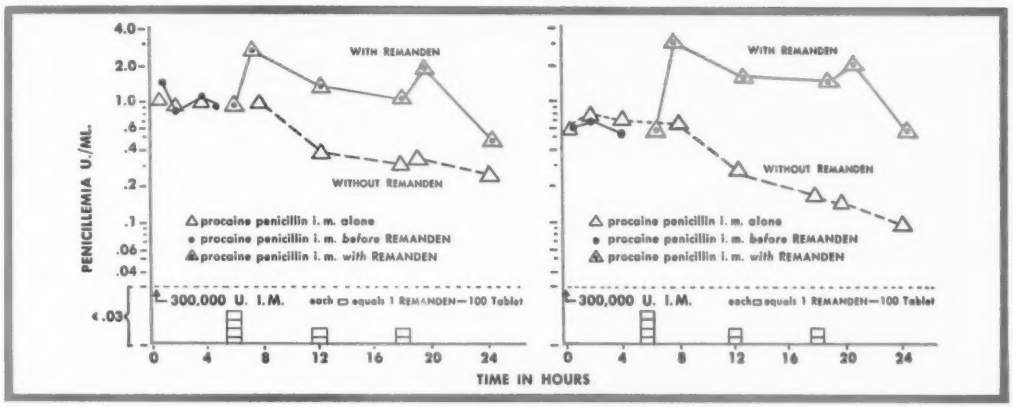

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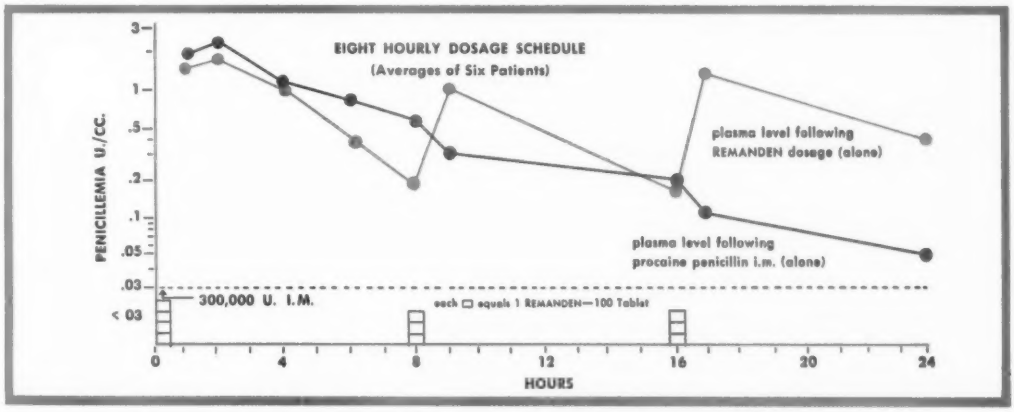

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